

**19-10651**

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IN THE  
**United States Court of Appeals  
FOR THE ELEVENTH CIRCUIT**

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DARREN MICKELL, an individual,

*Plaintiff-Appellant,*

—v.—

BERT BELL / PETE ROZELLE NFL PLAYERS RETIREMENT PLAN,  
a welfare benefit plan,

*Defendant-Appellee.*

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT  
FOR THE SOUTHERN DISTRICT OF FLORIDA

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**APPENDIX  
VOLUME IV OF VII**

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*Darren Mickell v. Bert Bell/Pete Rozelle NFL Players Retirement Plan*

No. 19-10651-A

**INDEX OF APPENDIX**

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## SAN DIEGO CHARGERS FOOTBALL CLUB HISTORY AND PHYSICAL EXAM

**INSTRUCTION:** This form is for your benefit; you must disclose all injuries or problems whether you consider them to have been serious or minor.

Name: Darren Mickell Position: DE Today's Date: 1-13-00  
Birth Date: 1-7-70 Age: 29 Place of Birth: Miami, FL  
Social Security Number: 123-45-6789 College Attended: Univ. of Florida  
Height: 6'5 Weight: 265 Total Years in Pro Sports: 7 Present Status: UF  
List Your Professional Teams: Team Kansas City Chiefs Years: 4  
Team New Orleans Saints Years: 3 Team \_\_\_\_\_ Years: \_\_\_\_\_

LABORATORY WORK

EKG

X-RAYS

GENERAL MEDICAL EXAMINATION/BLOOD PRESSURE / / /

ORTHOPEDIC EXAMINATION

DENTAL EXAMINATION

EYE EXAMINATION





**SAN DIEGO CHARGERS FOOTBALL CLUB**  
**MEDICAL EXAMINATION AND AUTHORIZATIONS**

Name: Darren Mickell Date: 1-14-00

Reference is made to the existing Standard Player Contract or NFL Player Contract between the San Diego Chargers (Club) and the undersigned (Player), as set forth in the "Contract" to his contractually required physical examination by the Club Physician given on this date.

A. **PRESENT PHYSICAL CONDITION:** I have previously warranted and represented the Club, under Paragraph 8 of my contract, that I am in excellent physical condition. Upon reporting to the Club, I filled out a "Health History" form, and was examined by Club Physicians. Recognizing that my true physical condition (and a physician's ability to ascertain same) is dependent upon an accurate medical history, I have fully disclosed, in writing, my prior medical history and present symptoms, complaints and ailments.

B. **COMPLETE DISCLOSURE:** I represent and warrant that at the time of this physical examination, I have made a full and complete disclosure, to the Club Physician conducting the exam, all existing and prior physical and mental defects, illnesses, injuries, and other conditions known to me. I have not withheld or failed to disclose to such Physician any existing or previous defect, illness, injury, impairment or other physical and/or mental condition of which I have knowledge.

C. **RELEASE:** I hereby fully release that Club, its successors and assigns, of and from any and all liability, claims, demands, damages, suits, and causes of action resulting from and/or arising out of, incident to, or in any manner, in connection with any existing or prior physical or mental defect, illness, injury or other condition known to me not disclosed to the club physician at the time of this physical examination, including but not limited to any aggravation or re-injury of or to any such existing or prior condition.

D. **FUTURE COMPLAINTS:** I acknowledge receipt of instructions from the Club that all future injuries, medical problems, ailments, complaints, re-injuries, and aggravations of old injuries must be immediately reported to the Club Athletic Trainers; no matter how minor or insignificant I deem them to be.

E. **RELEASE EXAMINATION:** I acknowledge receipt of instructions from the Club that I must submit to another physical examination by a Club Physician at the season's conclusion, or in the event of my being traded or being placed on waivers; at which time I shall record in writing all symptoms, complaints or ailments, if any, I may be experiencing.

F. **CLUB MEDICAL RECORDS:** I hereby authorize the Club to transfer and forward my complete medical record and files to any other NFL Club to which my contract may be traded or assigned. Such authorization extends to the Club's Physicians and their successors and to any hospital, clinic or institution to which I may be referred or admitted in connection with any illness, injury, test or treatment and I hereby release all of such persons and institutions from any and all claims by reason thereof.

G. **PRIOR MEDICAL RECORDS:** I hereby authorize and empower the Club and its representatives to examine, copy and/or obtain copies of any and all medical records relating to my prior health history, injury, complaints, tests, findings and treatments and I hereby authorize all physicians, hospitals, clinics, schools, colleges, NFL Clubs and other professional teams or organizations that may possess such records, to make them freely available to Club representatives. I do hereby release and discharge all such persons and institutions from any and all claims by reason thereof.

H. **MEDICAL TREATMENT:** I hereby authorize the Club Team Physicians and Medical Consultants to examine and treat any injuries which may occur while playing for the Club. I authorize the Team Physicians and Medical Consultants to communicate with the Club Officials regarding their findings and recommendations. I also authorize the Club Athletic Trainers to treat any and all such injuries which occur while playing for the Club.

**WORKERS COMPENSATION:** I acknowledge that I have received a copy of the updated pamphlet entitled facts About Workers Compensation. I have read this and understand it.

Darren Mickell  
Player-Signature

Scott Sulcer  
Witness

1-14-00  
Date

\_\_\_\_\_  
Date

## SAN DIEGO CHARGERS FOOTBALL CLUB HISTORY AND PHYSICAL EXAM

**INSTRUCTION:** This form is for your benefit: you must disclose all injuries or problems whether you consider them to have been serious or minor.

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ College Attended: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Total Years in Pro Sports: \_\_\_\_\_ Present Status: \_\_\_\_\_  
List Your Professional Teams: Team \_\_\_\_\_ Years: \_\_\_\_\_  
Team \_\_\_\_\_ Years: \_\_\_\_\_ Team \_\_\_\_\_ Years: \_\_\_\_\_  
Team \_\_\_\_\_ Years: \_\_\_\_\_

LABORATORY WORK

EKG

X-RAYS

GENERAL MEDICAL EXAMINATION/BLOOD PRESSURE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

ORTHOPEDIC EXAMINATION

DENTAL EXAMINATION

EYE EXAMINATION



## **EXPLANATION OF ALL "YES" ANSWERS ON HEALTH HISTORY**

Please list ALL hospitalizations for medical illnesses. List the dates and reason for the hospitalizations.  
DATE: REASON:

DATE: REASON:

FC 4405  
Gents 3pm

Please list ALL inpatient and outpatient surgeries including arthroscopes that you have had. List the date, nature of the operation, the doctor's name who did the operation and the city where you had the operation done.

DATE: OPERATION: DOCTOR: CITY:  
1990 (1) knee Arthroscopic Team DR Gainesville FL  
1995 (B) knees " " KC MC  
1998 (P) shoulder " " " New Orleans

NAME: Damon Mitchell DATE: 1-13-00

**SAN DIEGO CHARGERS FOOTBALL CLUB  
GENERAL MEDICAL PHYSICAL EXAMINATION**

Height	Weight
Pulse	B.P.
General Appearance	
Skin	
Head, Eyes	
Ears	
Nose	
Mouth and Pharynx	
Tongue	
Teeth	
Neck	
Lymph Nodes	
Thyroid	
Lungs	
Heart	
Abdomen	
Hernia	
External Genitalia	
Joints	
Neurological Exam	
NAME:	DATE:

**SAN DIEGO CHARGERS FOOTBALL CLUB  
ORTHOPAEDIC EXAMINATION**

NAME: Darren Mickell DATE: 1-13-00

1. CONCUSSION: No  Yes \_\_\_\_\_; Year/s \_\_\_\_\_; Recurrent \_\_\_\_\_; MRI \_\_\_\_\_; CT-Scan \_\_\_\_\_

If YES, Describe: \_\_\_\_\_

2. NECK: History of Injury: No  Yes \_\_\_\_\_ If YES, Describe /Findings: \_\_\_\_\_

Range of Motion: Normal \_\_\_\_\_; Restricted \_\_\_\_\_; Burners: No \_\_\_\_\_ Yes \_\_\_\_\_

MRI: No \_\_\_\_\_; Yes \_\_\_\_\_; C-Spine X-Rays: No \_\_\_\_\_; Yes \_\_\_\_\_; Findings: \_\_\_\_\_

3. SHOULDER: History of Injury: Right: No \_\_\_\_\_; Yes  Date: 1998

Left: No \_\_\_\_\_; Yes \_\_\_\_\_; Date: \_\_\_\_\_

If YES, Describe: (R) Shoulder Arthroscopy .

Range of Motion: Right: Normal ; Restricted \_\_\_\_\_

Left: Normal ; Restricted \_\_\_\_\_

Dislocation: No  Yes \_\_\_\_\_; X-Rays: No \_\_\_\_\_; Yes \_\_\_\_\_; Surgery: No \_\_\_\_\_ Yes \_\_\_\_\_

Findings: Severe Posterior Pt Excellent Strength  
X-ray - recurrent C7 ant acromion Acet humerus

4. ELBOW / ARM: History of Injury: Right: No  Yes \_\_\_\_\_; Date: \_\_\_\_\_

Left: No  Yes \_\_\_\_\_; Date: \_\_\_\_\_

If YES, Describe: \_\_\_\_\_

Range of Motion: Right: Normal ; Restricted \_\_\_\_\_

Left: Normal ; Restricted \_\_\_\_\_

Dislocation: No \_\_\_\_\_; Yes \_\_\_\_\_; X-Rays: No \_\_\_\_\_; Yes \_\_\_\_\_; Findings: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**X-RAY FINDINGS, SUMMARY AND RECOMMENDATIONS:** \_\_\_\_\_

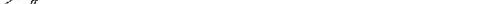
1234567890

 PASSED  FAILED

**REASONS:** \_\_\_\_\_

**FURTHER TESTS NEEDED:**

EXAMINING PHYSICIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

I do hereby attest that the answers and information given are true to the best of my knowledge, including the reporting of all injuries to date. 

SIGNATURE OF PLAYER: \_\_\_\_\_ DATE: \_\_\_\_\_



## HEALTH HISTORY

NAME Darren Mickell DATE 1-13-00

INSTRUCTIONS:

Answer each of the following questions. Fully explain all questions that were answered YES in the space below. List the question number, dates, procedures, hospitalization and Doctors' names where appropriate.

**HAVE YOU EVER HAD OR ARE YOU CURRENTLY EXPERIENCING:**

	NO	YES		NO	YES
1. Rheumatic fever?	✓		23. Frequent cough after exercise?	✓	
2. Malaria?	✓		24. Frequent abdominal pain?	✓	
3. Hepatitis (Jaundice)?	✓		25. Frequent indigestion (Heart burn)?	✓	
4. Meningitis?	✓		26. Stomach or peptic ulcer?	✓	
5. Tuberculosis?	✓		27. Appendicitis?	✓	
6. Mononucleosis?	✓		28. Colitis or bowel disease?	✓	
7. Gonorrhea or Syphilis?	✓		29. Constipation?	✓	
8. Frequent Skin Infections or Boils?	✓		30. Frequent or bloody diarrhea?	✓	
9. Sinusitis?	✓		31. Hemorrhoids or rectal bleeding?	✓	
10. Frequent upper respiratory infections?	✓		32. Liver or gall bladder disease?	✓	
11. Pneumonia or pleurisy?	✓		33. Kidney or bladder infections?	✓	
12. Frequent sore throats?	✓		34. Kidney or gall bladder stones?	✓	
13. Epilepsy (seizure)?	✓		35. Difficulty or pain urinating?	✓	
14. Frequent headaches?	✓		36. Passed blood, pus, or sugar in urine?	✓	
15. Migraine headaches?	✓		37. Sex problems?	✓	
16. Dizziness?	✓		38. Hernia?	✓	
17. Chest pain with exercise?	✓		39. Diabetes?	✓	
18. Fainted/Passed out?	✓		40. Thyroid trouble?	✓	
19. High or low blood pressure?	✓		41. Anemia or sickle cell trait?	✓	
20. Irregular heart beat?	✓		42. Ear disease, injury or impaired function?	✓	
21. Heart murmur?	✓		43. Eye disease, injury or impaired function?	✓	
22. Asthma?	✓		44. Cancer (Tumor)?	✓	
45. Depression, nervous breakdown, seen or been advised to see a psychiatrist?					
46. Any drug or narcotic habit or have been treated for one?					
47. A single paired organ (one eye, kidney or testicle)?					
48. Any illness or condition not listed above? If so give details below.					

List the question number and give details to all YES questions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NAME Darren Mickell DATE 1-13-00

PERSONAL INFORMATION	NO	YES	QUANTITY/FREQUENCY
Do you wear glasses or contacts?			
Do you have false teeth or bridge work?			
Do you smoke cigarettes? If so how much?			
Do you dip snuff or chew tobacco? If so how much?			
Do you drink alcoholic beverages? If so how much?			
Do you take any medications? If so please list.			
A.			
B.			
C.			
D.			

FAMILY HISTORY	Mother	Father	Brother(s)	Sister(s)	Others
If alive list age(s).					
If deceased list age when occurred.					
Has a history of:					
Heart disease					
Stroke					
High blood pressure					
Cancer					
Diabetes					
Epilepsy					
Mental illness					
Blood diseases: sickle cell anemia or trait, leukemia etc.					
Has any family member died of a heart attack under the age of 50 years of age?					YES / NO
Does any family member have a drug or alcohol problem?					YES / NO

ALLERGIES	NO	YES	If YES describe the reaction you had.
Penicillin			
Sulfa medications			
Tetracycline medications			
Codeine			
Aspirin			
Anti-inflammatory medications			
Tetanus Antitoxin or Serums			
Others (list medications and foods)			Describe reaction
a.			
b.			
c.			
d.			
e.			

PRIOR IMMUNIZATIONS	NO	YES	Approximate date of last shot
Tetanus			
Measles			
Chickenpox			

NAME \_\_\_\_\_ DATE \_\_\_\_\_

5. WRIST: History of Injury: Right: No  ; Yes \_\_\_\_\_; Date: \_\_\_\_\_Left: No  ; Yes \_\_\_\_\_; Date: \_\_\_\_\_

If YES, Describe: \_\_\_\_\_

Range of Motion: Right: Normal  ; Restricted \_\_\_\_\_Left: Normal  ; Restricted \_\_\_\_\_

Dislocation: No \_\_\_\_\_; Yes \_\_\_\_\_; X-Rays: No \_\_\_\_\_; Yes \_\_\_\_\_; Findings: \_\_\_\_\_

6. HAND: History of Injury: Right: No  ; Yes \_\_\_\_\_; Date: \_\_\_\_\_Left: No  ; Yes \_\_\_\_\_; Date: \_\_\_\_\_

If YES, Describe: \_\_\_\_\_

Range of Motion: Right: Normal  ; Restricted \_\_\_\_\_Left: Normal  ; Restricted \_\_\_\_\_ *pt little old bountainer**fixed*

X-Rays: No \_\_\_\_\_; Yes \_\_\_\_\_; Findings: \_\_\_\_\_

7. FINGERS: History of Injury: Right: No  ; Yes \_\_\_\_\_; Date: \_\_\_\_\_Left: No  ; Yes \_\_\_\_\_; Date: \_\_\_\_\_

If YES, Describe: \_\_\_\_\_

Range of Motion: Right: Normal  ; Restricted \_\_\_\_\_Left: Normal  ; Restricted \_\_\_\_\_

X-Rays: No \_\_\_\_\_; Yes \_\_\_\_\_; Findings: \_\_\_\_\_

8. SPINE / LOW BACK: History of Injury: No  ; Yes \_\_\_\_\_; If YES, Describe: \_\_\_\_\_

X-Rays: No \_\_\_\_\_; Yes \_\_\_\_\_; Findings: \_\_\_\_\_

Range of Motion: Normal  ; Restricted \_\_\_\_\_; Flexibility \_\_\_\_\_

Spondylolysis: No \_\_\_\_\_; Yes \_\_\_\_\_; Spondylolisthesis: No \_\_\_\_\_; Yes \_\_\_\_\_

MRI: No \_\_\_\_\_; Yes \_\_\_\_\_; CT Scan: No \_\_\_\_\_; Yes \_\_\_\_\_; Bone Scan: No \_\_\_\_\_; Yes \_\_\_\_\_

9. RIB FRACTURE: History of Injury: No ; Yes \_\_\_\_\_; Right \_\_\_\_\_; Left \_\_\_\_\_

Sternum: No \_\_\_\_\_; Yes \_\_\_\_\_; X-Rays: No \_\_\_\_\_; Yes \_\_\_\_\_

If YES, Describe: \_\_\_\_\_

10. HIP: History of Injury: Right: No ; Yes \_\_\_\_\_; Date: \_\_\_\_\_Left: No ; Yes \_\_\_\_\_; Date: \_\_\_\_\_

If YES, Describe: \_\_\_\_\_

Range of Motion: Right: Normal ; Restricted \_\_\_\_\_Left: Normal ; Restricted \_\_\_\_\_

Leg Length: Right: \_\_\_\_\_; Left: \_\_\_\_\_

11. HAMSTRING: History of Injury: Right: No ; Yes \_\_\_\_\_; Date: \_\_\_\_\_Left: No ; Yes \_\_\_\_\_; Date: \_\_\_\_\_

If YES, Describe: \_\_\_\_\_

Ever Injected?: No \_\_\_\_\_; Yes \_\_\_\_\_

Recurrent: No \_\_\_\_\_; Yes \_\_\_\_\_ Date/s: \_\_\_\_\_

Flexibility: W12. GROIN: History of Injury: Right: No ; Yes \_\_\_\_\_; Date: \_\_\_\_\_Left: No ; Yes \_\_\_\_\_; Date: \_\_\_\_\_

If YES, Describe: \_\_\_\_\_

Ever Injected?: No \_\_\_\_\_; Yes \_\_\_\_\_

Recurrent: No \_\_\_\_\_; Yes \_\_\_\_\_ Date/s: \_\_\_\_\_

Flexibility: W



## 16. ACHILLES TENDON / TENDONITIS:

History of Injury: Right: No  Yes \_\_\_\_\_; Date: \_\_\_\_\_

Left: No \_\_\_\_\_; Yes \_\_\_\_\_; Date: \_\_\_\_\_

If YES, Describe: \_\_\_\_\_

Surgery: No \_\_\_\_\_; Yes \_\_\_\_\_; Type: Scope: \_\_\_\_\_; Reconstruction: \_\_\_\_\_

Range of Motion: Right: Normal  Restricted \_\_\_\_\_Left: Normal  Restricted \_\_\_\_\_

Recurrent Problem?: No \_\_\_\_\_ Yes \_\_\_\_\_

Has Injured Area Ever Been Injected?: No \_\_\_\_\_; Yes \_\_\_\_\_; Date/s \_\_\_\_\_

17. FOOT / TOES: History of Injury: Right: No  Yes \_\_\_\_\_; Date: \_\_\_\_\_Left: No  Yes \_\_\_\_\_; Date: \_\_\_\_\_

If YES, Describe: \_\_\_\_\_

Surgery: No \_\_\_\_\_; Yes \_\_\_\_\_; Type: Scope: \_\_\_\_\_; Reconstruction: \_\_\_\_\_

Range of Motion: Right: Normal  Restricted \_\_\_\_\_Left: Normal  Restricted \_\_\_\_\_

Instability: Right: \_\_\_\_\_; Left: \_\_\_\_\_; Recurrent: No \_\_\_\_\_; Yes \_\_\_\_\_

Fracture/s: No \_\_\_\_\_; Yes \_\_\_\_\_; Type: \_\_\_\_\_

Surgery: No \_\_\_\_\_; Yes \_\_\_\_\_; Date/s \_\_\_\_\_; Hardware \_\_\_\_\_

X-Rays: No \_\_\_\_\_; Yes \_\_\_\_\_; Date / Findings: \_\_\_\_\_

Great Toe / Turf Toe/s: No \_\_\_\_\_; Yes \_\_\_\_\_; Injections: No \_\_\_\_\_; Yes \_\_\_\_\_

Orthotics Worn?: No \_\_\_\_\_; Yes \_\_\_\_\_

## 18. Has Any Body Part Ever Been Injected For Play or Practice? No \_\_\_\_\_; Yes \_\_\_\_\_

If YES, Body Part/s and Date/s: \_\_\_\_\_

## 19. Medications presently taking and reason: \_\_\_\_\_

GENERAL REMARKS AND FINDINGS:

Left shoulder show recurrent C5/T2 and also  
Left AC joint narrow - Exam is very benign  
Lg. - Knees show - Patello femoral narrow latera  
Lateral rotator

RECOMMENDATIONS AND / OR FURTHER TEST / EVALUATIONS:

He has acute ankle sprain that  
prevents him from playing  
I expect this will resolve  
in 3 weeks time. However  
today he does not pass the test

PASSED

FAILED

because of acute ankle sprain

1/10/00  
DATE OF EXAMINATION

Paul C. Murray  
SIGNATURE OF EXAMINING PHYSICIAN

L. G. Mickell  
SIGNATURE OF PLAYER

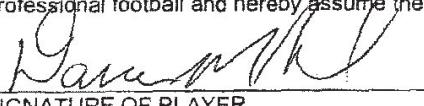
## SAN DIEGO CHARGERS DISCLOSURE / INFORMED CONSENT

I have received a full explanation from the examining physician as to my present condition and medical findings from this examination in pages 1 through 6 of this document as well as what proper treatment and/or care of such stated findings should be followed.

I have received a full explanation from the examining physician that to play professional football may result in the aggravation or deterioration of such physical condition(s).

I hereby affirm that all statements on pages 1 through 6 are true and correct and that no information has been withheld pertaining to my past and present physical, mental and injury history. If any information is false or omitted in reference to my medical history I fully understand that the San Diego Chargers Football Club is not responsible for any unknown past medical history.

I fully understand the possible consequences of playing professional football with the condition(s) described in pages 1 through 6 of this examination. Nonetheless, I desire to continue to play professional football and hereby assume the risk of the matters as described.

  
SIGNATURE OF PLAYER

  
SIGNATURE OF EXAMINING PHYSICIAN

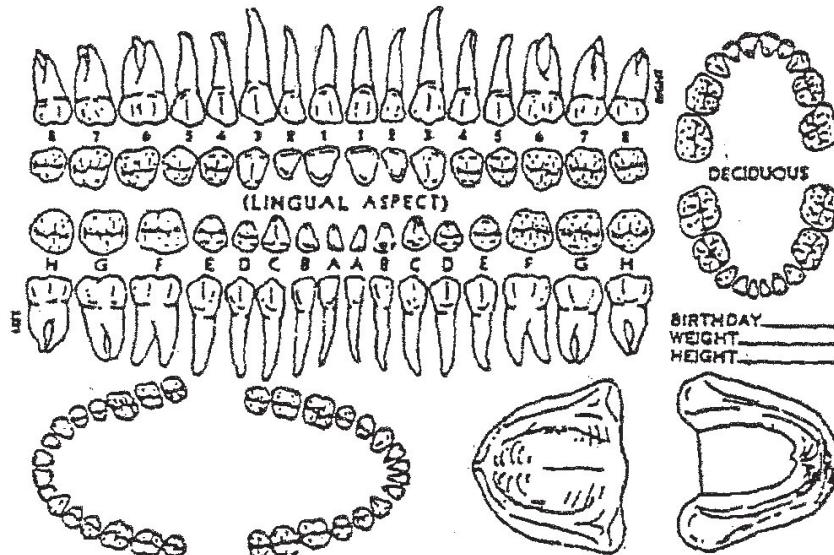
WITNESS

DATE

SAN DIEGO CHARGERS FOOTBALL CLUB  
DENTAL EXAM

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

HISTORY: \_\_\_\_\_



FINDINGS & SUMMARY: \_\_\_\_\_

EXAMINING DENTIST: \_\_\_\_\_ DATE: \_\_\_\_\_

## SAN DIEGO CHARGERS FREE AGENT WAIVER FORM

### READ CAREFULLY THIS IS A FREE AGENT WAIVER AND RELEASE OF LIABILITY

WHEREAS, Darren Mickell (hereinafter known as the Undersigned) who is not an Employee of the San Diego Chargers, has a desire to participate in various exercises and workouts at the San Diego Chargers training facility, and;

WHEREAS, the Undersigned declares and warrants:

- A. That he neither has now, nor has he ever had an illness, disease, injury, infirmity, disability of any kind or nature, or any physical or mental condition which might be aggravated or caused to become active again by any reason of physical or mental activity and stress involved in or required by the activities of a football player; and
- B. That he fully understand the risk involved in that it is possible to sustain serious injury during the course of said exercises and workouts; and
- C. That he acknowledges that he has been made no promise of employment and understands that allowing him to participate in the football tryouts does not constitute employment by the San Diego Chargers,

NOW, THEREFORE, in consideration of the opportunity to participate in the aforementioned exercise and workouts, I, the Undersigned, fully covenant not to sue and forever discharge the San Diego Chargers, its officers, agents, partners, employees, athletic trainers, physicians, players, coaches and the National Football League (hereinafter known as Releasees) from any and all liability to the Undersigned, my personal representative, assigns, heirs and next of kin for any and all loss or damage and any claims or demands thereof on account of injury to the person or property or resulting in the death of the Undersigned, whether caused by negligence of Releasees or otherwise.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND FULLY UNDERSTAND ITS CONTENT

Player's Signature: Darren Mickell Date: 1-13-00

Printed Signature: Darren Mickell

Witness Signature: \_\_\_\_\_



San Diego Chargers  
4020 Murphy Canyon Rd  
San Diego, CA  
92123

## Athletic Training Dept Fax

To: Dean Kleinschmidt From: Scott Trulock

Fax: 504-731-1805 Fax: 858-292-2763

Re: Darren Mickell Phone: 858-874-4506

Date: 3-21-00 Pages: 2

Urgent  For Review  Please Comment  Please Reply  Please Recycle

Please send a copy of the medical file for this player at your convenience. I have included the signed release for medical information. Please call me if you have any questions.

Thanks for your help,

A handwritten signature in cursive script that appears to read "Scott".



MICKELL-0649

A0765

**SAN DIEGO CHARGERS FOOTBALL CLUB**  
**MEDICAL EXAMINATION AND AUTHORIZATIONS**

Name: Darren MickellDate: 1-14-00

Reference is made to the existing Standard Player Contract or NFL Player Contract between the San Diego Chargers (Club) and the undersigned (Player), as set forth in the "Contract" to his contractually required physical examination by the Club Physician given on this date.

A. **PRESENT PHYSICAL CONDITION:** I have previously warranted and represented the Club, under Paragraph 8 of my contract, that I am in excellent physical condition. Upon reporting to the Club, I filled out a "Health History" form, and was examined by Club Physicians. Recognizing that my true physical condition (and a physician's ability to ascertain same) is dependent upon an accurate medical history, I have fully disclosed, in writing, my prior medical history and present symptoms, complaints and ailments.

B. **COMPLETE DISCLOSURE:** I represent and warrant that at the time of this physical examination, I have made a full and complete disclosure, to the Club Physician conducting the exam, all existing and prior physical and mental defects, illnesses, injuries, and other conditions known to me. I have not withheld or failed to disclose to such Physician any existing or previous defect, illness, injury, impairment or other physical and/or mental condition of which I have knowledge.

C. **RELEASE:** I hereby fully release that Club, its successors and assigns, of and from any and all liability, claims, demands, damages, suits, and causes of action resulting from and/or arising out of, incident to, or in any manner, in connection with any existing or prior physical or mental defect, illness, injury or other condition known to me not disclosed to the club physician at the time of this physical examination, including but not limited to any aggravation or re-injury of or to any such existing or prior condition.

D. **FUTURE COMPLAINTS:** I acknowledge receipt of instructions from the Club that all future injuries, medical problems, ailments, complaints, re-injuries, and aggravations of old injuries must be immediately reported to the Club Athletic Trainers; no matter how minor or insignificant I deem them to be.

E. **RELEASE EXAMINATION:** I acknowledge receipt of instructions from the Club that I must submit to another physical examination by a Club Physician at the season's conclusion, or in the event of my being traded or being placed on waivers; at which time I shall record in writing all symptoms, complaints or ailments, if any, I may be experiencing.

F. **CLUB MEDICAL RECORDS:** I hereby authorize the Club to transfer and forward my complete medical record and files to any other NFL Club to which my contract may be traded or assigned. Such authorization extends to the Club's Physicians and their successors and to any hospital, clinic or institution to which I may be referred or admitted in connection with any illness, injury, test or treatment and I hereby release all of such persons and institutions from any and all claims by reason thereof.

G. **PRIOR MEDICAL RECORDS:** I hereby authorize and empower the Club and its representatives to examine, copy and/or obtain copies of any and all medical records relating to my prior health history, injury, complaints, tests, findings and treatments and I hereby authorize all physicians, hospitals, clinics, schools, colleges, NFL Clubs and other professional teams or organizations that may possess such records, to make them freely available to Club representatives. I do hereby release and discharge all such persons and institutions from any and all claims by reason thereof.

H. **MEDICAL TREATMENT:** I hereby authorize the Club Team Physicians and Medical Consultants to examine and treat any injuries which may occur while playing for the Club. I authorize the Team Physicians and Medical Consultants to communicate with the Club Officials regarding their findings and recommendations. I also authorize the Club Athletic Trainers to treat any and all such injuries which occur while playing for the Club.

**WORKERS COMPENSATION:** I acknowledge that I have received a copy of the updated pamphlet entitled facts About Workers Compensation. I have read this and understand it.

Player Signature Darren MickellDate 1-14-00Witness Scott Sulser

Date

HEALTH RECORD

NAME: MICKELL, DARREN

ORTHOPAEDIC PROBLEMS:

MEDICAL PROBLEMS:

RISK:

MICKELL-0651

A0767

NEW ORLEANS SAINTS

MICKELL, DARREN

MEDICAL HISTORY

ORTHOPEDIC:

Hs. of LBP,  Bilat Knee Soreness Arthroscopy (3x, 2xR), Hs. B: Lat Foot Spr.  
1993 -  ACSpr.,  Hand Spr.,  Ankle Spr.  
1995 -  ACSpr.,  Little Finger Dislocation,  Ankle Spr.

MEDICAL:

ALLERGIES:

MICKELL-0652

A0768

*F.H.*  
Southern Orthopaedic Specialists  
Drs. Williams, Habig, Moss, Millet, Finney and Hoffman

Southern Orthopaedic Specialists

Drs. Williams, Habig, Moss, Millet, Finney and Hoffman  
2731 Napoleon Avenue, New Orleans, LA 70115 • (504) 897-6351

<b>Patient Name:</b> Darren Mickell
<b>File Number:</b> 11-7498-2
<b>Account Number:</b> 68000
<b>Claim Number:</b>
<b>Date of Visit:</b> Wednesday, September 15, 1999
<b>NAPOLEON OFFICE</b>

**Chief Complaint:** Physical examination for the New Orleans Saints

**Present Illness:** Mr. Mickell is a 29 year-old single male. He did not play professional football last year. He is here for a physical examination

he had right shoulder surgery in February of 98 by Dr. Finney. He states that his right shoulder is doing fine. He denies having any pain. He has a history of surgery on both knees. He states the last surgery was in 1995. This was performed in Kansas City and was for chondromalacia of the patella. He states that his knees are doing fine at this time. He denies being on any medication. He denies having any swelling of either knee. He has a history of having a back problem in 1996 but he had an MRI performed which was negative for a ruptured disc. He states that he has occasional low back pain particularly early in the season when he is lifting weights and getting into shape. He currently denies any complaints of back pain or leg pain. He also has a history of injury to his right little finger and has lost motion in that finger. He has a history of injuries to his right long and ring fingers in 1993 and a dislocation to the left long finger in 1994

**Review of Systems:** Unchanged.

**Past Medical History:** Unchanged.

**Physical Examination:** Shoulder exam showed full range of motion bilaterally. Rotator cuff strength appeared normal bilaterally. He had no apprehension with abduction/external rotation

right hand exam showed a 35 degree flexion contracture of the right little finger at the P. IP joint

back exam showed full range of motion. Straight leg raise negative to 90 °. Reflexes symmetrical.

Knee exam shows moderate patellofemoral crepitus with active range of motion of the right knee with advanced crepitus with active range of motion of the left knee. No evidence of effusion to either knees.

No instability. Negative McMurray's test bilaterally

*Southern Orthopaedic Specialists*  
Drs. Williams, Habig, Moss, Millet, Finney and Hoffman  
2731 Napoleon Avenue, New Orleans, LA 70115 • (504) 897-6351

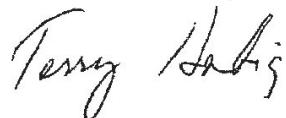
**Medical Decision-Making:**

**X-Rays:** X-rays of his knees in standing AP view show that he has excellent joint space bilaterally. A lateral x-ray of the left knee shows irregularity on the undersurface of the patella consistent with chondromalacia of the patella

**Impression:**

1. Chondromalacia patella, advanced left knee, moderate right knee
2. Status post arthroscopy right shoulder with satisfactory outcome
3. History of recurrent lumbosacral strain-he probably has a degenerative lumbar disc

**Plan:** I believe that this patient is able to play professional football. I think his biggest concern would be his left knee. Most likely his left knee will flare up on him or becomes sore with practicing and playing everyday but thickly on a hard surface. He will probably require NSAIDs. He has had some back problems also but usually this type problem has resolved with conservative management. I would rate this player at the 3 level



Terry L. Habig, M.D.

cc: Coach Mike Ditka

cc: Mr. Dean Kleinschmidt ✓

cc: Mr. Bill Kuharch

NOTICE: Bills will be submitted for payment to Medicare, Medicaid, all other governmental programs, and third party carriers based upon the diagnostic information provided by the treating physician.

CLIENT ID:

**CLIENT NAME:**

## PHONE

ABN Attached

## Memorial Medical Center

Tenet Louisiana HealthSystem

PATIENT NAME	Last Name <i>Nickell</i>	First <i>Darren</i>	MI <i>M</i>	SEX <i>M</i>	AGE OF PATIENT <i>70</i>	
COLLECTION DATE/TIME	LAST NAME <i>1926</i>		REQUESTING PHYSICIAN <i>Carlos Brown</i>			
BILL TO:		Responsible Party's Last Name <i>1354 W. Espana de St. Kenner, LA. 700</i>	First <i>1354 W. Espana de St. Kenner, LA. 700</i>	Initial <i>S</i>	Relationship <i>Spouse</i>	Phone <i>(504) 467-3000</i>
<input type="checkbox"/> Patient <input type="checkbox"/> Client Account <input type="checkbox"/> Insurance <input type="checkbox"/> Champus <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Branch  <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Workers Comp.		Address: <i>New Orleans Saints</i>		Ins. Phone <i>3800 Airline Dr. Met. La. 1000</i>		
		Insurance Co. Name/Coverage (Attach Copy of Card) <i>3800 Airline Dr. Met. La. 1000</i>		Ins. Phone <i>3800 Airline Dr. Met. La. 1000</i>		
		Insurance Co. Address <i>3800 Airline Dr. Met. La. 1000</i>		Certificate of Death/Death/Medicare/Medicaid ID # <i>1926</i>		
		Employer <i>1926</i>		Date of Injury if Workers Comp. <i>1926</i>		

**General Instructions for Governmental Payers:** All orders for clinical laboratory tests must include a statement of the medical reason for those tests. The reason(s) listed below must be linked with the test(s) ordered by noting the number of the reason in the space next to the test ordered. If a specific test is not supported by documentation in the medical record or is clearly for screening purposes, the test must be designated as a "Screening Test" and must be accompanied by the signed ABN.

Reasons for admission ICD-9 Code

### Reason

1. Prop. name : \_\_\_\_\_ 2. \_\_\_\_\_

3.

5. **Screening Tests:** All tests ordered for the purpose of screening, including tests ordered as part of routine physical examinations, must be accompanied by an ABN completed by the

3. Screening Test: An order created for the ordering physician and signed by the patient.

ABN (Billing Authorization Before Non-urgent Services) is a form completed by the ordering physician and signed by the patient. Laboratories may not bill for the services unless the ABN has been completed and signed by the patient prior to the rendition of the service(s).

#### PHYSICIAN ACKNOWLEDGEMENT AND CERTIFICATION

**PHYSICIAN ACKNOWLEDGEMENT AND CERTIFICATION:**  
The undersigned physician certifies for the Hospital/Laboratory that either: 1. The tests ordered are medically necessary and specific tests ordered on this requisition are necessary for the diagnosis and treatment of the patient; the physician is treating the patient in connection with the diagnoses or complaints listed on this requisition; the information on this requisition accurately reflects the medical reasons for the specific tests ordered on this requisition; and the medical necessity of each of the individual tests ordered on this requisition is appropriately documented in the patient's medical record; or 2. The tests ordered are for purposes of screening that the physician believes is appropriate for the patient even though the payor may not allow reimbursement for the tests; and the fact that payment is likely to be denied by Medicare or other payors has been explained to the patient, who has agreed to pay for the tests personally by signing the attached Advance Beneficiary Notice (ABN).

SIGNATURE

## PATHOLOGY TEST REQUISITION

MICKELL-0655

A0771

## DEPARTMENT OF PATHOLOGY

Dr. Charles L. Brown, Jr.  
2633 Napoleon Ave., #310  
New Orleans, La 70115

*File*  
 ✓ PATIENT: MICKELL, DAREN  
 PAT REG# 000007000434816  
 ADV/FIN# 0000058812251  
 SEX/AGE: MALE 29 YES  
 DR. BROWN, CHARLES L.  
 LOCATION: WPO - DR  
 ADMIT DATE: 09/15/99  
 DISCHARGE DATE: 09/15/99

## CHEMISTRY

COLLECTION DATE 09/15/99  
 WEEKDAY/DAY OF STAY WED 001  
 COLLECTION TIME 1034  
 UNIT (REFERENCE)

**ELECTROLYTES**  
 SODIUM mEq/L (137-143) 140  
 POTASSIUM mEq/L (3.5-5.0) 4.0  
 CHLORIDE mEq/L (99-108) 103  
 CO2 mEq/L (22-30) 31H  
 ANION GAP mEq/L (8-16) 62

**CHEMISTRY**  
 GLUCOSE mg/dL (70-110) 105  
 BUN mg/dL (8-21) 15  
 CREATININE mg/dL (0.2-1.4) 1.2  
 B/CR mg/dL 12.3  
 CALCIUM mg/dL (8.7-10.7) 9.5  
 BILIRUBIN TOTAL mg/dL (0.2-1.3) 0.8  
 TOTAL PROTEIN g/dL (6.3-8.0) 7.2  
 ALBUMIN g/dL (3.8-5.0) 4.6  
 A/G RATIO g/dL (1.1-2.0) 1.7

**ENZYMES**  
 SGOT U/L (10-34) 33  
 ALK PHOS U/L (50-100) 76

**THYROID SCREEN**  
 T3 UPTAKE % (28.0-46.0) 38.5  
 T4 ug/dL (4.0-12.0) 6.4  
 T7 (1.1-5.5) 2.8  
 TSH mIU/mL (3.5-6.50) 3.31

## LEGEND

L = Low, H = High

Included on Page: CHEMISTRY

Printed: 09/15/99

Continued ..  
Page: 1

FINAL

P.03

SEP-20-1999 08:24

MICKELL-0656

A0772

PRINT DATE: 09/15/99  
 PRINT TIME: 1756  
 ADMIT DATE: 15SEP99

PAGE 3

PATIENT: MICKELL, DAREN  
 PAT MRN: (00000)000434816  
 APM/PIN: 000005802251  
 SEX/AGE: MALE 29 YES  
 DR: BROWN, CHARLES L.  
 LOCATION: UPO

## HEMATOLOGY

COLLECTION DATE 09/15/99  
 WEEDAY/DAY OF STAY MED 001  
 COLLECTION TIME 1034  
 UNIT (REFERENCE)

## MISCELLANEOUS HEMATOLOGY

SICKLE CELL, SCR (NEG) NEG

## URINALYSIS

COLLECTION DATE 09/15/99  
 WEEDAY/DAY OF STAY MED 001  
 COLLECTION TIME 1123  
 UNIT (REFERENCE)

## MACROSCOPIC

COL TYPE	UNSPC		
PH	(4.6-8.0)	5.0	
PROTEIN	(NEG)	NEG	
GLUCOSE	(NEG)	NEG	
KETONES	(NEG)	NEG	
BILE	(NEG)	NEG	
BLOOD	(NEG)	NEG	
APPEARANCE	CLEAR		
COLOR	(STR-BNG)	DKYELLOW	
SPEC GRAV	>1.030f		
U LEUK EST	(NEG)	NEG	
NITRITE	(NEG)	NEG	
UROBILIN	E. U/g	(0.2-1.0)	0.2
SPEC GRAV	NORMAL RANGE: 1.003 - 1.025		

MICKELL-0657

A0773

PRINT DATE: 09/15/99  
 PRINT TIME: 1756  
 ADMIT DATE: 15SEP99

PAGE 2

PATIENT: MICKELL, DAEREE  
 PAT NR: (00000) 000434816  
 ADM/PIN: 0000058222E1  
 SEX/AGE: MALE 25 YES  
 DR: BROWN, CHARLES L.  
 LOCATION: WFO

## CHEMISTRY

COLLECTION DATE 09/15/99  
 WEEKDAY/DAY OF STAY WED 001  
 COLLECTION TIME 1034

## UNIT (REFERENCE)

## LIPID PROFILE

CHOLESTEROL	mg/dL	167 <sup>f</sup>
TRIGLYCERIDE	mg/dL	119 <sup>f</sup>
IDL	mg/dL (38-55)	46
LDL	mg/dL	113 <sup>f</sup>
CHOLESTEROL	DESIRABLE: <200 mg/dL	BORDERLINE: 200-239 mg/dL HIGH: = OR >240 mg/dL
TRIGLYCERIDE	DESIRABLE: <200mg/dL	BORDERLINE: 200-500mg/dL HIGH: >500mg/dL
IDL	END	
LDL	DESIRABLE: <130mg/dL	BORDERLINE: 130-189mg/dL HIGH: >189mg/dL

## HEMATOLOGY

COLLECTION DATE 09/15/99  
 WEEKDAY/DAY OF STAY WED 001  
 COLLECTION TIME 1034

## UNIT (REFERENCE)

## CELL COUNTS

WBC	/cmm (3.5-11.0)	5.4
RBC	/cmm (4.30-8.50)	4.89
HGB	g/dL (13.3-16.7)	14.8
HCT	% (39.0-49.0)	48.1
MCV	uM3 (83.0-98.0)	92.1
MCH	pg (27.5-33.5)	30.4
MCHC	g/dL (32.0-36.0)	32.9
RDW	% (11.5-14.5)	13.5
PLATELET	/cmm (150-350)	261
MPV	uM3 (7.4-10.4)	7.8
Z LYMPH	% (15.0-41.0)	42.1H
Z MONO	% (3.0-12.0)	6.7
Z NEUTROPHILS	% (45.0-75.0)	48.2
Z EOS	% (0.0-7.0)	2.6
Z BASO	% (0.0-3.0)	0.4

## LEGEND

H = High, F = Footnote  
 Included on Page:  
 Printed: 09/15/99

CHEMISTRY

HEMATOLOGY

Continued  
 Page: 2

FINAL

P. 04

SEP-20-1999 08:24

MICKELL-0658

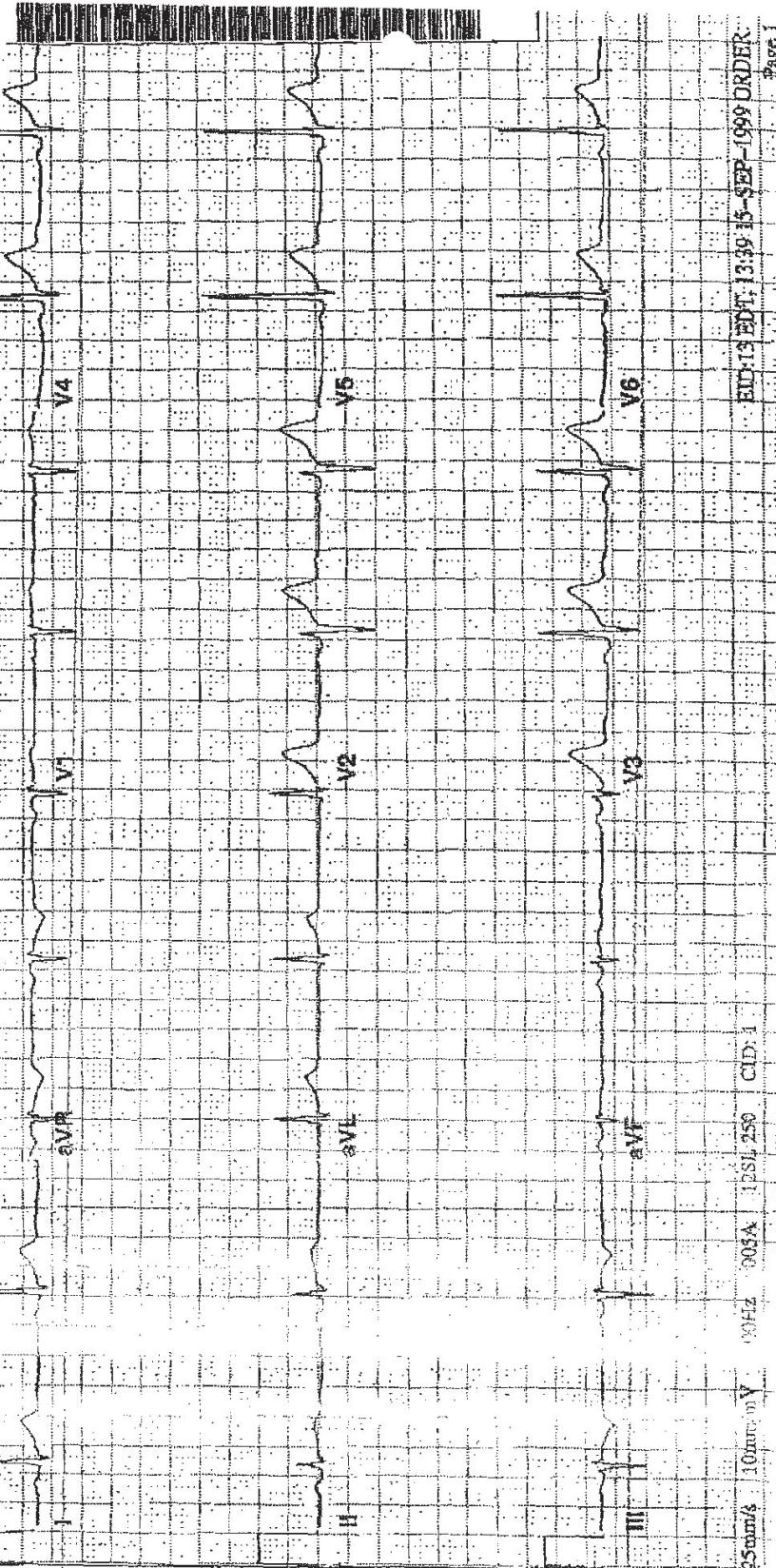
A0774

Mickell, barren 1026175-1926 15 SE 992-09-13-08 MEMORIAL MEDICAL CENTER-CARD T TINE RECORD

29 yr	53 BPM	Stasis edema
Male	68 BPM	periorbital, costovertebral, T12-L1
75yr	92 BPM	abdominal, ECG
100% of control		
100% of control		

THE NEW COME

Reference: CHARLES BROWN, *THE HISTORY AND STUDIO OF SCHABEWAN*.



3906  
EU-13 ED.1 1339-15-22-199 ORDER  
3906

MICKELL-0659

A0775

P.DA

5048975943

SEP-15-1999 12:32

DEPARTMENT OF PATHOLOGY

Dr. Charles L. Brown, Jr.  
2633 Napoleon Ave., 6910  
New Orleans, La 70115

PATIENT: MICKELL, BARRON  
PAT NR: (0000)000434816  
ADM/FIN: 00000302251  
SEX/AGE: MALE 29 yrs  
DR. BROWN, CHARLES L. JR  
LOCATION: WFO - DRN 0000102  
ADMIT DATE: 09/15/99  
DISCHARGE DATE: 09/15/99

CHEMISTRY

COLLECTION DATE 09/15/99  
WEEKDAY/DAY OF STAY MON 001  
COLLECTION TIME 1034  
UNIT (REFERENCE)

ELECTROLYTES  
Na<sup>+</sup> mmol/L 137-151 140  
K<sup>+</sup> mmol/L 3.5-5.0 4.0  
Cl<sup>-</sup> mmol/L 99-108 103  
HCO<sub>3</sub><sup>-</sup> mmol/L 22-30 30H  
OM GAP mmol/L 18-16 16

CHEMISTRY  
BUN mg/dL (70-110) 105  
Cr mg/dL (8-21) 15  
BUN/CREATINE mg/dL (10.2-1.4) 1.2  
R mg/dL 12.3  
CtHb mg/dL (8.7-10.7) 9.5  
IMUR TOTAL mg/dL (0.2-1.3) 0.8  
AL PROTEIN g/dL (6.3-8.0) 7.2  
URIN g/dL (3.5-5.0) 4.6  
URIN/AL RATIO g/dL (1.1-2.0) 1.7

BALANCES  
U mmol/L (10-34) 33  
PHOS mmol/L (50-100) 76

THYROID SCREEN  
URINE T 3 (08.0-46.0) 35.0  
URINE T 4 (4.0-12.0) 6.4  
TSH (1.1-5.5) 2.0  
URINE T 3 (08.0-46.0) 35.0

END  
Low, H = High  
Dated on Page: CHEMISTRY  
Dated: 09/15/99

Continued on  
Page: 1

09/15/1999 13:38 FAX 5048975943

MICKELL-0660

A0776

P.02

5848975943

SEP-15-1999 12:33

PRINT DATE: 09/15/99  
PRINT TIME: 13:33  
ADMIT DATE: 10/08/99

PAGE 2

PATIENT: MICKELL, BRYAN  
PAT. NR.: 10000000043486  
ADMIT NR.: 0000580229  
SEX/AGE: MALE 29 yrs  
DR. BRUN, CHARLES L. JR  
LOCATION: UPD

CHEMISTRY

COLLECTION DATE 09/15/99  
MEDIUM/DAY OF STAY NED 001  
COLLECTION TIME 1034  
UNIT (REFERENCE)  
===== LIPID PROFILE =====  
ESTEROL mg/dL 167f  
LYCERIDE mg/dL 119f  
mg/mL (35-55) 46  
mg/mL 113f  
ESTEROL DESIRABLE: <200 mg/dL BORDERLINE: 200-239 mg/dL HIGH: >240 mg/dL  
LYCERIDE DESIRABLE: <200 mg/dL BORDERLINE: 200-500 mg/dL HIGH: >500 mg/dL  
END  
DESIRABLE: <130 mg/dL BORDERLINE: 130-159 mg/dL HIGH: >159 mg/dL

HEMATOLOGY

COLLECTION DATE 09/15/99  
MEDIUM/DAY OF STAY NED 001  
COLLECTION TIME 1034  
UNIT (REFERENCE)  
===== CELL COUNTS =====  
RBC (3.5-11.0) 5.4  
Hct 43.36-5.50 43.95  
g/dL (13.3-16.7) 14.8  
M (39.0-49.0) 45.1  
WBC (3.0-7.0) 7.1  
mg 127.4-33.01 30.4  
g/dL (32.0-44.0) 32.4  
% (11.5-14.5) 13.5  
RDW (150-160) 159  
% 7.8 12.0  
Hb g/dL (15.0-41.0) 42.04  
% (13.0-18.0) 6.7  
% (4.1-6.2) 4.1  
% (0.0-7.0) 2.6  
% (10.0-3.0) 0.6  
%  
Hg  
High, f = Footnote  
dated on Page: 2  
dated 09/15/99

CHEMISTRY HEMATOLOGY

Continued on  
Page: 2

MICKELL-0661

A0777

P.03

5048975943

SEP-15-1999 12:33

PRINT DATE: 09/15/99  
PRINT TIME: 1343  
ADMIT DATE: 1555P99

PAGE 3

PATIENT: MICKELL, WARREN  
PAT NR#: 1003801000434016  
ADM/DR#: 00000520225  
SEX/AGE: MALE 29 YRS  
DR. BROWN, CHARLES L. JR  
LOCATION: UPU

HEMATOLOGY

COLLECTION DATE 09/15/99  
HOSPITAL/DAY OF STAY MED 001  
COLLECTION TIME 1034  
UNIT (REFERENCE)

MISCELLANEOUS HEMATOLOGY

LE CELL SCR (NEG) NEG

URINALYSIS

COLLECTION DATE 09/15/99  
HOSPITAL/DAY OF STAY MED 001  
COLLECTION TIME 1123  
UNIT (REFERENCE)

MICROSCOPIC

TYPE	UNSPEC
URINE	(4.6-8.0) 5.0
EIN	(NEG)
OSE	(NEG)
RES	(NEG)
W	(NEG)
URINE	(NEG)
R	(STR-NEG) DRY/YELLOW
GRAN	>1,000
WBC EST	(NEG)
ITE	(NEG)
OLDE	E. U. 0.0 (0.2-1.0) 0.2
U-40	

NORMAL RANGE: 1.00 - 1.02

NO  
Footnote

Test: 09/15/99

DEPARTMENT OF PATHOLOGY

MICKELL, WARREN

END OF REPORT

PAGE: 3

MICKELL-0662

A0778



MEMORIAL MEDICAL CENTER

BAPTIST CAMPUS

2700 NAPOLEON AVE

NEW ORLEANS, LA 70135

PHONE (504) 897-5957 FAX (504) 897-4459

RADIOLOGY CONSULTATION REPORT

OUT

Name: MICKELL, DARREN Acct No. 5802251  
Room: [REDACTED] DOB: 7/70 MR#: 00434816 E#, E-00967717  
Exam: CHEST XRAY, TWO VIEWS DX: PA LAT CXR ERG PNY EXAM  
Adm MD: CHARLES L. BROWN, JR, M.D. Att MD: CHARLES L. BROWN, JR, M.D.  
Ord MD: CHARLES L. BROWN, JR, M.D. Ref MD: CHARLES L. BROWN, JR, M.D.

Dictated by: REUBEN L CHRESTMAN, III, M.D. Completed by: SW Sep 15, 1999 10:04:00  
Approved by:  
Ordered by:

\*\* NOTICE: Preliminary report. Not Approved by a Radiologist. \*\*

Clinical: Physical Exam

CHEST, EPA AND LATERAL: 71020

The heart is not enlarged. Each lung is well aerated and clear.

RC/vk/6835

Transcription

Dictation Time Sep 15, 1999 13:05

SEP-15-1999 12:59

P.01

MICKELL-0663

A0779

NI ORLEANS SAINTS FOOTBALL CI 3

## PLAYER'S HEALTH HISTORY

28y 6'4 1/2  
UPW 285

NAME:	Darren Mickell		HOME PHONE #:	767-3099
ADDRESS:	1354 W Esplanade <sup>APT 10</sup>	CITY:	STATE: LA	ZIP: 70065

## 1. IF YOU HAVE HAD ANY OF THE FOLLOWING, PLEASE CHECK (✓) BESIDE THAT ITEM:

MUMPS .....	<input type="checkbox"/>	RUPTURE .....	<input type="checkbox"/>	STOMACH, LIVER OR BOWEL DIS. ....	<input type="checkbox"/>
SCARLET FEVER.....	<input type="checkbox"/>	HEMORRHOIDS.....	<input type="checkbox"/>	BONE OR JOINT DEFORMITY.....	<input type="checkbox"/>
DIPHTHERIA.....	<input type="checkbox"/>	TUMOR, GROWTH, CANCER.....	<input type="checkbox"/>	LOSS OF FINGER, TOE, ETC. ....	<input type="checkbox"/>
PNEUMONIA.....	<input type="checkbox"/>	KIDNEY STONE OR INFECT.....	<input type="checkbox"/>	PAINFUL SHOULDER OR ELBOW. ....	<input type="checkbox"/>
RHEUMATIC FEVER.....	<input type="checkbox"/>	SKIN DISEASE.....	<input type="checkbox"/>	"TRICK" OR LOCKED KNEE.....	<input type="checkbox"/>
HAY FEVER.....	<input type="checkbox"/>	VENEREAL DISEASE.....	<input type="checkbox"/>	BACK TROUBLE.....	<input type="checkbox"/>
ASTHMA.....	<input type="checkbox"/>	FREQUENT HEADACHES.....	<input type="checkbox"/>	LEG CRAMPS.....	<input type="checkbox"/>
GOITER (THYROID).....	<input type="checkbox"/>	DIZZY OR FAINTING.....	<input type="checkbox"/>	FOOT TROUBLE .....	<input type="checkbox"/>
TUBERCULOSIS.....	<input type="checkbox"/>	VISUAL DIFFICULTIES .....	<input type="checkbox"/>	CAR, TRAIN, AIR SICKNESS.....	<input type="checkbox"/>
FREQUENT SORE THROAT....	<input type="checkbox"/>	EAR, NOSE, THROAT DIS. ....	<input type="checkbox"/>	DIFFICULTY SLEEPING.....	<input type="checkbox"/>
DIABETES .....	<input type="checkbox"/>	CHRONIC, FREQUENT COLDS .....	<input type="checkbox"/>	DEPRESSION OR NERVOUSNESS..	<input type="checkbox"/>
HEART MURMUR.....	<input type="checkbox"/>	SINUSITIS .....	<input type="checkbox"/>	LOSS OF MEMORY .....	<input type="checkbox"/>
HIGH BLOOD PRESSURE.....	<input type="checkbox"/>	CHEST PAIN OR PRESSURE.....	<input type="checkbox"/>	CHRONIC COUGH .....	<input type="checkbox"/>
NIGHT SWEATS.....	<input type="checkbox"/>	APPENDICITIS.....	<input type="checkbox"/>	FREQUENT INDIGESTION.....	<input type="checkbox"/>

## 2. HAVE YOU EVER: (ANSWER YES OR NO)

WORN GLASSES NO LIVED WITH ANYONE WHO HAD TUBERCULOSIS NO  
 WORN HEARING AIDS NO BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION NO  
 STUTTERED OR STAMMERED NO HAD ANY REACTION TO SERUM, DRUGS OR MEDICINE NO  
 WORN A BACK BRACE OR SUPPORT NO

## 3. LIST ALL OPERATIONS, FRACTURES, INJURIES, AND SERIOUS ILLNESSES THAT YOU HAVE HAD:

Shoulder &amp; Knee Operat. n

4. ARE YOU TAKING ANY MEDICATIONS AT THIS TIME? NO WHAT? \_\_\_\_\_5. ARE THERE ANY SERIOUS ILLNESSES IN YOUR IMMEDIATE FAMILY? NO PLEASE LIST ILLNESSES:

\* NOTE: LIST "L &amp; W" IF LIVING AND WELL -- LIST "DEC." IF DECEASED.

MOTHER \_\_\_\_\_

FATHER \_\_\_\_\_

BROTHERS & SISTERS 1 son

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION AND THAT IT IS TRUE THE BEST OF MY KNOWLEDGE.

9-15-99

DATE

Darell Mickell

PLAYER'S SIGNATURE

MICKELL-0664

A0780

NEW ORLEANS SAINTS FOOTBALL CLUB  
GENERAL PHYSICAL EXAMINATION

NAME: \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Temp. \_\_\_\_\_  
Chest Measurement \_\_\_\_\_ Abdominal Meas. \_\_\_\_\_  
Inspir. Expir.  
General Appearance \_\_\_\_\_ ✓  
Head, Scalp and Face \_\_\_\_\_ ✓  
Eyes \_\_\_\_\_ ✓ Visual Acuity: L: 20/ \_\_\_\_\_ R: 20/ \_\_\_\_\_  
Ears (and Drums) \_\_\_\_\_ ✓ Nose \_\_\_\_\_ ✓  
Mouth \_\_\_\_\_ ✓ Teeth \_\_\_\_\_  
Throat \_\_\_\_\_ ✓ Sinuses \_\_\_\_\_ ✓ Tonsils \_\_\_\_\_  
Chest \_\_\_\_\_ Lungs \_\_\_\_\_ ✓  
Heart \_\_\_\_\_  
Blood Pressure (Sitting): 120 | 80      Pulse Rate \_\_\_\_\_ After Exer. \_\_\_\_\_  
(Other): 2 Min. After Exer. \_\_\_\_\_  
Abdomen \_\_\_\_\_ Genitalia \_\_\_\_\_ Hernia \_\_\_\_\_  
Skin \_\_\_\_\_  
Lymphatics: Neck \_\_\_\_\_ Axilla \_\_\_\_\_ Epitrochlear \_\_\_\_\_ Inguinal \_\_\_\_\_  
Anus - Rectum \_\_\_\_\_

LABORATORY (DATES)

ECG \_\_\_\_\_ X-RAYS: Chest \_\_\_\_\_ Other \_\_\_\_\_  
SEROLOGY \_\_\_\_\_ HEMOGLOBIN \_\_\_\_\_  
URINALYSIS: Alb. \_\_\_\_\_ Sugar \_\_\_\_\_ Occult Bl. \_\_\_\_\_ Acet. \_\_\_\_\_

IMMUNIZATIONS (DATES)

Tetanus \_\_\_\_\_ Influenza \_\_\_\_\_ Polio \_\_\_\_\_  
Other \_\_\_\_\_

PHYSICIAN'S SUMMARY Hydrocele - R

5/15/99  
Date

CAB  
Physician's Signature

W ORLEANS SAINTS FOOTBALL UB  
ORTHOPEDIC EXAMINATION

NAME \_\_\_\_\_ DATE \_\_\_\_\_

1. NECK:

History of Injury: No  Yes  (If Yes, Describe) \_\_\_\_\_

Range of Motion: Normal  Restricted  \_\_\_\_\_

2. SHOULDER:

History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe) *Feb 98 - O/C now* \_\_\_\_\_

Range of Motion: Right: Normal  Restricted  Left: Normal  Restricted  *Stiff, pain* \_\_\_\_\_

3. ELBOW SECTION:

History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe) \_\_\_\_\_

Range of Motion: Right: Normal  Restricted  Left: Normal  Restricted  \_\_\_\_\_

4. WRIST:

History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe) \_\_\_\_\_

Range of Motion: Right: Normal  Restricted  Left: Normal  Restricted  \_\_\_\_\_

5. HAND:

History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe) *Blistered finger - 5 years ago* \_\_\_\_\_

Range of Motion: Right: Normal  Restricted  Left: Normal  Restricted  *Callus - 30% function* \_\_\_\_\_

6. FINGERS:

History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe) *Callus* \_\_\_\_\_

Deformity: \_\_\_\_\_

7. SPINE:

History of Injury: No  Yes  (If Yes, Describe) *O/C back pain M/R 1996* \_\_\_\_\_

Posture: \_\_\_\_\_

Range of Motion: Normal  Restricted  \_\_\_\_\_

NAME: \_\_\_\_\_

Page 2

8. HIP:

History of Injury: Right: No  Yes  Left: No  Yes  ( If Yes, Describe) \_\_\_\_\_

Range of Motion: Right: Normal \_\_\_\_\_ Restricted \_\_\_\_\_ Left: Normal \_\_\_\_\_ Restricted \_\_\_\_\_

9. KNEE:

History of Injury: Right: No  Yes  Left: No  Yes  ( If Yes, Describe) \_\_\_\_\_

Measurements: Thigh: Right  Left  Calf: Right  Left

Motion and Stability: Right:  $0^{\circ} 3^{\circ} F R$   $3^{\circ} C P F L$   $0^{\circ} 0^{\circ} 0^{\circ}$

Left:  $0^{\circ} 3^{\circ} F R$   $3^{\circ} C P F L$   $0^{\circ} 0^{\circ} 0^{\circ}$

10. ANKLE:

History of Injury: Right: No  Yes  Left: No  Yes  ( If Yes, Describe) \_\_\_\_\_

Range of Motion: Right: Normal  Restricted  Left: Normal  Restricted

Stability: Right: \_\_\_\_\_ Left: \_\_\_\_\_

11. FOOT:

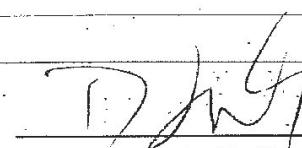
History of Injury: Right: No  Yes  Left: No  Yes  ( If Yes, Describe) \_\_\_\_\_

12. ACHILLES:

History of Injury: Right: No  Yes  Left: No  Yes  ( If Yes, Describe) \_\_\_\_\_

GENERAL REMARKS: \_\_\_\_\_

Date: \_\_\_\_\_



Physician's Signature

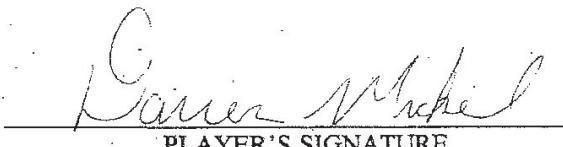
**WARRANTY OF FULL DISCLOSURE OF THE  
PHYSICAL AND MENTAL CONDITION OF PLAYER**

To: New Orleans Saints  
5800 Airline Highway  
Metairie, LA 70003

Player warrants and represents that he has made a full and complete disclosure to the Club's physician of all present or prior physical or mental defects, illnesses, injuries, or conditions known to him or of which he has knowledge, which might prevent, hinder, or impair the performance of his services under his standard player contract. Player further warrants that at the time of his physical examination by the Club's physician on the 15 day of Sept 1999, he has not withheld or failed to disclose any present or previous physical or mental defect, illness, injury, or condition known to him. Player understands and agrees that if any answers given during said physical examination are false or if any information has been withheld, such physical examination will be void and will necessitate the taking of another physical examination to determine the true physical status of the player. Player further agrees to indemnify and hold the Club harmless from the consequence of any injury, illness or deteriorated condition occurring to player during the life of his standard player contract which is attributable to or the result of any defect, illness, injury or condition which player failed to disclose to the Club at the time of his examination.

WORKERS COMPENSATION BENEFITS MAY BE DENIED IF MEDICAL HISTORY IS DETERMINED TO BE FALSE.

Date: 9-15-99

  
\_\_\_\_\_  
PLAYER'S SIGNATURE

*Southern Orthopaedic Specialists*  
Williams, Habig, Moss, Millet, Finney and Hoff  
2731 Napoleon Avenue, New Orleans, LA 70115 • (504) 874-6351

RE: Darren Mickell  
Our file: 11-7498-2  
Our account: 6800

June 15, 1998

METAIRIE OFFICE:

**Chief complaint:** Follow-up, right shoulder arthroscopy.

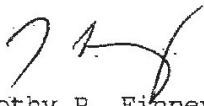
**Present illness:** Today is Darren's first postoperative visit. He is doing well, with minimal complaints. He had significant labral pathology as well as some rotator cuff fraying. He also underwent subacromial decompression.

**Physical examination:** The patient's right shoulder portals are healing well. Range of motion is excellent at this point in his rehab. He has no drainage or erythema.

**Diagnosis:** Status post right shoulder arthroscopy, doing well.

**Plan:** I would like to place him in formal physical therapy for right shoulder stretching and strengthening.

He will follow-up with me in four weeks.

  
Timothy P. Finney, M.D.

TPF/cm

cc: Coach Mike Ditka  
cc: Mr. Dean Kleinschmidt ✓  
cc: Mr. Bill Kuharich

MICKELL-0669

A0785

New Orleans Saints

Postseason Physical Examination

Name: Mickell, Warren Date: 12/12/97

Head: History of Injury No  Yes \_\_\_\_\_ If Yes, Describe: \_\_\_\_\_

Neck: History of Injury No  Yes \_\_\_\_\_ If Yes, Describe: \_\_\_\_\_

Shoulder: History of Injury No \_\_\_\_\_ Yes  If Yes, Describe: Right shoulder - rotator cuff

Upper Extremity: History of Injury No  Yes \_\_\_\_\_ If Yes, Describe: \_\_\_\_\_

Back: History of Injury No  Yes \_\_\_\_\_ If Yes, Describe: \_\_\_\_\_

Knee: History of Injury No \_\_\_\_\_ Yes  If Yes, Describe: Right knee - pain

Lower Extremity: History of Injury No  Yes \_\_\_\_\_ If Yes, Describe: \_\_\_\_\_

Physician's Comments: Right shoulder, right knee; both have mild tendinitis.  
Right knee, I found tendinitis, pain.  
See back in 1 month.

Examiner's Signature: [Signature] Date: 12/12/97

I have been examined by the above named Team Physician and agree with the findings. I have no known physical condition other than those listed above.

Player's Signature: [Signature] Date: 12/12/97

NEW ORLEANS SAINTS  
PLAYER EMERGENCY INFORMATIONNAME: Darren MickellSOCIAL SECURITY #: ██████████ 1926BIRTHDATE: ██████████ 70LOCAL PHONE #: 504 441 6799

ALLERGIES: \_\_\_\_\_

EMERGENCY CONTACT: Patricia SmithRELATIONSHIP: MonEMERGENCY CONTACT PHONE #: 954-437-8742

*Southern Orthopaedic Specialists*  
 Williams, Habig, Moss, Millet, Finney and Hoff  
 2731 Napoleon Avenue, New Orleans, LA 70115 \* (504) 897-6351

RE: Darren Mickell  
 Our file: 11-7498-2  
 Our account: 6800

March 4, 1998

**Chief complaint:** Evaluation, right shoulder.

**Present illness:** Darren reports that he initially injured his right shoulder approximately a year ago in a mini-camp with the Saints, and he played throughout the 1997 season with some tenderness of the right shoulder area. He localizes the tenderness over the anterior biceps tendon region. He also has pain with any overhead activities or bench-press lifting activities. He denies any history of subluxation or dislocation of the shoulder.

**Physical examination:** Darren's right shoulder has full range of motion. He does have a positive Speed test. There is point tenderness over the anterior biceps region; the biceps tendon is intact. He does have mild impingement with cross-body adduction of the Jobe maneuver. His rotator cuff strength appears to be adequate.

**Diagnoses:** Evidence of right shoulder bicipital tenosynovitis; possible SLAP lesion, with mild subacromial impingement.

**Plan:** At this point, I sat down with him at length to discuss the options of treatment, with the risks, benefits and limitations of operative versus non-operative treatment. I think because the symptoms have been going on for this long that arthroscopic evaluation of the right shoulder is in order, with possible repair of the SLAP lesion, with subacromial decompression. We will try to schedule this within the next few weeks.

Timothy P. Finney, M.D.

TPF/cm

cc: Coach Mike Ditka  
 cc: Mr. Dean Kleinschmidt  
 cc: Mr. Bill Kuharich

MICKELL-0672

A0788

210

Southern Orthopaedic Specialists  
Williams, Habig, Moss, Millet, Finney and Hoffm  
2731 Napoleon Avenue, New Orleans, LA 70115 \* (504) 897-6351

F14

RE: Darren Mickell  
Our file: 11-7498-2  
Our account: 6800

February 20, 1998

METAIRIE OFFICE:

**Chief complaint:** Right shoulder pain.

**Present illness:** Darren is here for his right shoulder. He had problems with the right shoulder during the season, and had an MRI last Summer, with a questionable partial tear of the rotator cuff. The shoulder bothered him during the season, and it continues to bother him. He rested during the off season, but he complains of pain when he moves the shoulder. In fact, he thinks that the pain has gotten worse.

**Physical examination:** Reveals that his shoulder has some pain with range of motion. He moves it a little slowly, particularly with overhead elevation. Rotator cuff strength shows slight weakness which appears to be secondary to pain.

**Medical decision making -**

**Diagnosis:** Rotator cuff tendinitis; possible partial tear.

**Plan:** I feel that since his symptoms have not improved, that he would benefit from arthroscopy of the rotator cuff, and probable acromioplasty. We will set this up.

He is to see Dr. Timothy Finney for this.

Terry L. Habig, M.D.

TLH/cc  
cc: Coach Mike Ditka  
cc: Mr. Dean Kleinschmidt  
cc: Mr. Bill Kuharich

*Terry L. Habig*

MICKELL-0673

A0789

*Southern Orthopaedic Specialists*  
Williams, Habig, Moss, Millet, Finney and Hoff  
2731 Napoleon Avenue, New Orleans, LA 70115 • (504) 877-6351

December 10, 1997

**Darren Mickell** - Darren is here for follow-up regarding his right shoulder. He injured his shoulder in a game, but he never came in after the game to be seen, nor the next day. I had wanted to get an MRI, which we set up for yesterday. Then he canceled it on his own because he thought he was doing better. He had a right shoulder problem prior to the season. He had some partial tearing of the rotator cuff, treated with exercises, and he has done well. It got injured in a game and he has some soreness, although he does state that it is improving. He also is complaining of some pain in his left knee, located around the knee cap area. He has had previous surgery for chondromalacia of his patella.

Examination of his right shoulder reveals that he has fairly full motion, but he complains of pain with abduction and external rotation. Rotator cuff strength looks good, however, he does have pain with resistance to both abduction and external rotation. There is slight tenderness at the acromioclavicular joint, but there is no deformity and no instability.

Examination of the left knee shows no swelling. There is tenderness just lateral to the patella superiorly. There is full motion and no instability. There is some moderate crepitus. He has a clunking about the patellofemoral area with active range of motion. He has a negative McMurray test.

**Diagnoses:** 1) Strain to the rotator cuff of the right shoulder.  
2) Chondromalacia patella flare up of the left knee.

MICKELL-0674

A0790

**NEW ORLEANS SAINTS FOOTBALL CLUB**  
**SUPPLEMENTARY PHYSICAL EXAM**

PRINT NAME: Darren Mickell DATE: 7-17-97

**PLAYER STATEMENT:**

List any accident, injuries and/or illnesses since your last physical examination by the club physician. If none, write none.

Shoulder

I am not now suffering from any physical disability which prevents me from playing professional football.

Darren Mickell  
Player Signature

7-17-97  
Date

OR

I am now suffering from the following disability which presently prevents me from playing professional football.

Player Signature

Date

**PHYSICIAN EXAMINATION:**

(R) Schneider - No Complaints  
EST T RHM  
range of motion  
no apprehension

D. L. Mickell  
Club Physician Signature

7-17-97  
Date

# Southern Orthopaedic Specialists

GENERAL ORTHOPAEDIC SURGERY • SURGERY OF THE HAND • JOINT RECONSTRUCTION  
SPORTS MEDICINE • ARTHROSCOPIC SURGERY • SURGERY OF THE SPINE

Claude S. Williams, M.D.  
Terry L. Habig, M.D.  
J. Lee Moss, M.D.  
Chad W. Millet, M.D.  
Timothy P. Finney, M.D.  
Gregor J. Hoffman, M.D.

Daniel C. Riordan, M.D.  
Retired  
J. Kenneth Saer, M.D.  
Retired  
OFFICE ADMINISTRATOR  
Marion Eigenbrod

RE: Darren Mickell  
Our file: 11-7498-2  
Our account: 6800

June 2, 1997

TLH

Darren is here for his right shoulder. He injured the right shoulder at the last training mini camp when he was hit on the arm during one of the drills and he had some shoulder pain, located in the axillary portion/pectoral area, and a little bit of pain on the top. He was seen by me, and I felt that he had a sprain to the shoulder joint, possibly a strain to the rotator cuff, and he was placed on some exercises. He states that he was doing better with the shoulder but when spring football practice started he aggravated the shoulder again.

Darren saw Dr. Harlan Selesnick in Miami, Florida, this past weekend. Dr. Selesnick is the orthopaedic surgeon for the Miami Heat. Dr. Selesnick called me and indicated that he examined Darren, and he states that he had treated Darren once before for a subluxation to the left shoulder, which responded very nicely to rehabilitation. An MRI was ordered on Darren's right shoulder, and he indicated that the MRI was read by the radiologist as showing evidence of multi-directional instability, impingement syndrome, and partial tear of the rotator cuff. Dr. Selesnick indicated that his recommendation was rehabilitation at this point because of the closeness to the football season. He felt that there was a good chance that this would improve with rehabilitation, and he indicated to me that he had recommended this to Darren and his agent. He did indicate that if symptoms persisted, and Darren did not get well, then he may be a surgical candidate.

I have explained to Darren what my interpretation of the MRI showed, as well as my interpretation of what Dr. Selesnick had advised him.

Darren complains of some pain about the axilla area and points to the axilla/pectoralis area and states that sometimes it is on the top of the shoulder. He denies any feeling of instability. He states that practicing football has aggravated his shoulder.

640 Read Boulevard, Suite 120  
New Orleans, Louisiana 70127-3125  
(504) 244-9720  
FAX 245-0738

MAIN OFFICE  
2731 Napoléon Avenue  
New Orleans, Louisiana 70115-6953  
(504) 897-6351  
Business FAX 899-7317  
Medical FAX 897-6442

3800 Houma Boulevard, Suite 210  
Metairie, Louisiana 70006-4151  
(504) 455-9500  
FAX 455-1617

MICKELL-0676

A0792

RE: Darren Mickell  
Our file: 11-7498-2  
Our account: 6800  
Page 2  
June 2, 1997

Physical examination shows that he has no evidence of atrophy about the shoulder area. The pectoralis tendon is intact. He complains of pain with abduction and external rotation, and he complains of pain with internal rotation of his shoulder. Abduction can be carried out fully, but he complains of some pain overhead. He has no tenderness anteriorly or in the axilla area. He did have some tenderness to direct palpation of the right AC joint. Stressing the shoulder was difficult because he had a hard time trying to relax.

I have told Darren that it is not unusual to have some changes on the MRI, particularly in defensive and offensive linemen who use their shoulders a lot. It is difficult to state for sure if the abnormalities noted on the MRI were all caused by injury a month ago; certainly, since he is painful, however, we have to consider this as a possibility - we have to consider that he has a partial tear of the rotator cuff. I think sometimes it can be difficult to distinguish partial tearing from tendinitis.

I believe Darren's options would be surgical intervention versus rehabilitation. I believe that surgical intervention would take several months to recover from, and I have explained this to Darren. I believe that he has an excellent chance of recovering with rehabilitation but no one knows for sure what will happen.

My recommendation would be to rehabilitate the shoulder, specifically the rotator cuff. If the pain stays localized to the AC joint area, it might be worthwhile to try an injection into the joint. Darren indicated to me that at this point in time he would rather rehabilitate the shoulder than have surgery.

I will discuss the rehabilitation program with the trainer, Dean Kleinschmidt.

Terry L. Habig, M.D.

TLH/cm

cc: Coach Mike Ditka  
cc: Mr. Dean Kleinschmidt  
cc: Mr. Bill Kuharich

MICKELL-0677

A0793

MICKEL, DARREN (5/31/97) Discussed with the patient and patient's agent the findings of the MRI consistent with likely multidirectional instability. There is likely partial thickness rotator cuff tear near its distal attachment with tendinitis of the rotator cuff tendon and mild impingement. Probable small labral tear. Will initially recommend rehabilitation program to see if this is effective in decreasing his symptoms. He will discuss this with the New Orleans Saints' doctor, Dr. Habig. He will get a copy of the MRI scan and determine whether he thinks conservative treatment versus arthroscopic intervention is indicated. The plan is agreeable with the patient.

HS/amt

MICKEL, DARREN (5/31/97) TELEPHONE CONVERSATION: Discussed the findings of the MRI with Dr. Habig, the orthopaedist with the New Orleans Saints. He will followup with Darren Mickel next week.

HS/amt

MICKELL-0678

A0794

# Southern Orthopaedic Specialists

GENERAL ORTHOPAEDIC SURGERY • SURGERY OF THE HAND • JOINT RECONSTRUCTION  
SPORTS MEDICINE • ARTHROSCOPIC SURGERY • SURGERY OF THE SPINE

Claude S. Williams, M.D.  
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Gregor J. Hoffman, M.D.

Daniel C. Riordan, M.D.  
Retired  
J. Kenneth Saer, M.D.  
Retired  
OFFICE ADMINISTRATOR  
Marion Eigenbrad

RE: Darren Mickell  
Our file: 11-7498-2  
Our account: 6800

April 28, 1997

TLH

Darren states that he was participating in mini-camp on Friday, and he thinks he remembers his arm being out to the side in an abducted position and somebody hit it, and he strained it. He does not remember it feeling like it came out of socket but he gradually developed some pain in the shoulder, and that night it got worse and the next day he had increased pain. He states that toward the end of the season last year he had some burning in both shoulders, but the pain subsided. He has a history of a subluxation to the left shoulder while playing for Kansas City.

Examination of his shoulder reveals that he has no swelling or atrophy. He has no tenderness at the AC joint. He is just complaining of some pain with extreme ranges of motion of abduction and external rotation and internal rotation. He complains of pain in the axilla. His rotator cuff strength looks good, although he complains of pain with resistance to abduction. When stressing the shoulder anteriorly caused no pain. He has a little bit of pain when stressing the shoulder inferiorly. I could not detect any instability when stressing the shoulder.

X-rays of the shoulder in internal and external rotation views are negative.

My impression is sprain/strain to the shoulder joint capsule, and possibly rotator cuff.

I have suggested rest as far as stressing the shoulder, and rotator cuff strengthening as the pain diminishes.

Terry L. Habig, M. D.

TLH/cc

cc: Coach Mike Ditka  
cc: Mr. Dean Kleinschmidt  
cc: Mr. Bill Kuharich

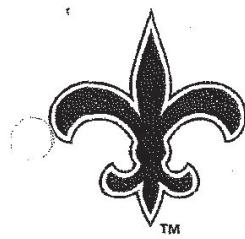
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3800 Houma Boulevard, Suite 210  
Metairie, Louisiana 70006-4151  
(504) 455-9500  
FAX 455-1617

MICKELL-0679

A0795



## NEW ORLEANS LOUISIANA SAINTS

5800 Airline Highway • Metairie, LA 70003 • 504-733-0255

Many drugs are harmful to individuals participating in strenuous physical activity.

It is important that you discuss with your doctor any drugs you are now taking.

Do not take any medication in Training Camp unless prescribed to you by the Team Physician.

I understand the above.

4/24/97

DATE

Dave Mickell

SIGNATURE

Dave Mickell

PRINT NAME

Keasha

2487528

MICKELL-0680

A0796

NEW ORLEANS SAINTS FOOTBALL UB  
PLAYER'S HEALTH HISTORY

NAME: _____	HOME PHONE #: _____		
ADDRESS: _____	CITY: _____	STATE: _____	ZIP: _____

1. IF YOU HAVE HAD ANY OF THE FOLLOWING, PLEASE CHECK (✓) BESIDE THAT ITEM:

MUMPS .....	<input type="checkbox"/>	RUPTURE .....	<input type="checkbox"/>	STOMACH, LIVER OR BOWEL DIS. <input type="checkbox"/>
SCARLET FEVER.....	<input type="checkbox"/>	HEMORRHOIDS.....	<input type="checkbox"/>	BONE OR JOINT DEFORMITY..... <input type="checkbox"/>
DIPHTHERIA.....	<input type="checkbox"/>	TUMOR, GROWTH, CANCER.....	<input type="checkbox"/>	LOSS OF FINGER, TOE, ETC. .... <input type="checkbox"/>
PNEUMONIA.....	<input type="checkbox"/>	KIDNEY STONE OR INFECT.....	<input type="checkbox"/>	PAINFUL SHOULDER OR ELBOW. <input type="checkbox"/>
RHEUMATIC FEVER.....	<input type="checkbox"/>	SKIN DISEASE.....	<input type="checkbox"/>	"TRICK" OR LOCKED KNEE..... <input type="checkbox"/>
HAY FEVER.....	<input type="checkbox"/>	VENEREAL DISEASE.....	<input type="checkbox"/>	BACK TROUBLE..... <input type="checkbox"/>
ASTHMA.....	<input type="checkbox"/>	FREQUENT HEADACHES.....	<input type="checkbox"/>	LEG CRAMPS..... <input type="checkbox"/>
GOITER (THYROID).....	<input type="checkbox"/>	DIZZY OR FAINTING.....	<input type="checkbox"/>	FOOT TROUBLE..... <input type="checkbox"/>
TUBERCULOSIS.....	<input type="checkbox"/>	VISUAL DIFFICULTIES.....	<input type="checkbox"/>	CAR, TRAIN, AIR SICKNESS..... <input type="checkbox"/>
FREQUENT SORE THROAT ...	<input type="checkbox"/>	EAR, NOSE, THROAT DIS. ....	<input type="checkbox"/>	DIFFICULTY SLEEPING..... <input type="checkbox"/>
DIABETES.....	<input type="checkbox"/>	CHRONIC, FREQUENT COLDS ...	<input type="checkbox"/>	DEPRESSION OR NERVOUSNESS.. <input type="checkbox"/>
HEART MURMUR.....	<input type="checkbox"/>	SINUSITIS.....	<input type="checkbox"/>	LOSS OF MEMORY..... <input type="checkbox"/>
HIGH BLOOD PRESSURE.....	<input type="checkbox"/>	CHEST PAIN OR PRESSURE.....	<input type="checkbox"/>	CHRONIC COUGH..... <input type="checkbox"/>
NIGHT SWEATS.....	<input type="checkbox"/>	APPENDICITIS.....	<input type="checkbox"/>	FREQUENT INDIGESTION..... <input type="checkbox"/>

2. HAVE YOU EVER: (ANSWER YES OR NO)

WORN GLASSES \_\_\_\_\_ LIVED WITH ANYONE WHO HAD TUBERCULOSIS \_\_\_\_\_  
WORN HEARING AIDS \_\_\_\_\_ BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION \_\_\_\_\_  
UTTERED OR STAMMERED \_\_\_\_\_ HAD ANY REACTION TO SERUM, DRUGS OR MEDICINE \_\_\_\_\_  
WORN A BACK BRACE OR SUPPORT \_\_\_\_\_

3. LIST ALL OPERATIONS, FRACTURES, INJURIES, AND SERIOUS ILLNESSES THAT YOU HAVE HAD:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. ARE YOU TAKING ANY MEDICATIONS AT THIS TIME? \_\_\_\_\_ WHAT? Ex. B. L. C. \_\_\_\_\_

5. ARE THERE ANY SERIOUS ILLNESSES IN YOUR IMMEDIATE FAMILY? \_\_\_\_\_ PLEASE LIST ILLNESSES:  
\* NOTE: LIST "L & W" IF LIVING AND WELL -- LIST "DEC." IF DECEASED.

MOTHER \_\_\_\_\_

FATHER \_\_\_\_\_

BROTHERS & SISTERS U.L.L.

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION AND THAT IT IS TRUE THE BEST OF MY KNOWLEDGE.

4-24-97

DATE

PLAYER'S SIGNATURE

NEW ORLEANS SAINTS FOOTBALL CLUB  
GENERAL PHYSICAL EXAMINATION

NAME: \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Temp. 99.0 °  
Chest Measurement \_\_\_\_\_ Abdominal Meas. \_\_\_\_\_  
Inspir. Expir.  
General Appearance \_\_\_\_\_  
Head, Scalp and Face \_\_\_\_\_  
Eyes \_\_\_\_\_ Visual Acuity: L: 20/25 R: 20/25  
Ears (and Drums) \_\_\_\_\_ Nose \_\_\_\_\_  
Mouth \_\_\_\_\_ Teeth \_\_\_\_\_  
Throat \_\_\_\_\_ Sinuses \_\_\_\_\_ Tonsils \_\_\_\_\_  
Chest \_\_\_\_\_ Lungs \_\_\_\_\_  
Heart \_\_\_\_\_  
Blood Pressure (Sitting): 130/70 Pulse Rate 64 After Exer. \_\_\_\_\_  
(Other): \_\_\_\_\_ 2 Min. After Exer. \_\_\_\_\_  
Abdomen \_\_\_\_\_ Genitalia \_\_\_\_\_ Hernia \_\_\_\_\_  
Skin \_\_\_\_\_  
Lymphatics: Neck \_\_\_\_\_ Axilla \_\_\_\_\_ Epitrochlear \_\_\_\_\_ Inguinal \_\_\_\_\_  
Anus - Rectum \_\_\_\_\_

LABORATORY (DATES)

ECG \_\_\_\_\_ X-RAYS: Chest \_\_\_\_\_ Other \_\_\_\_\_  
SEROLOGY \_\_\_\_\_ HEMOGLOBIN \_\_\_\_\_  
URINALYSIS: Alb. \_\_\_\_\_ Sugar \_\_\_\_\_ Occult Bl. \_\_\_\_\_ Acet. \_\_\_\_\_

IMMUNIZATIONS (DATES)

Tetanus \_\_\_\_\_ Influenza \_\_\_\_\_ Polio \_\_\_\_\_  
Cmer \_\_\_\_\_

PHYSICIAN'S SUMMARY \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date

Physician's Signature

NAME: \_\_\_\_\_

Page 2

8. HIP:

History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe) \_\_\_\_\_

Range of Motion: Right: Normal  Restricted  Left: Normal  Restricted

9. KNEE:

History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe) \_\_\_\_\_

Measurements: Thigh: Right Left Calf: Right Left

Motion and Stability: Right:

1/0 Jswellin

2-3 P flexion

Left:

1/0 Jswellin

2-3 P flexion

10. ANKLE:

History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe) \_\_\_\_\_

Range of Motion: Right: Normal  Restricted  Left: Normal  Restricted

Stability: Right: Left:

11. FOOT:

History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe) \_\_\_\_\_

12. ACHILLES:

History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe) \_\_\_\_\_

GENERAL REMARKS: \_\_\_\_\_

Date

Physician's Signature

**WARRANTY OF FULL DISCLOSURE OF THE  
PHYSICAL AND MENTAL CONDITION OF PLAYER**

To: New Orleans Saints  
5800 Airline Highway  
Metairie, LA 70003

Player warrants and represents that he has made a full and complete disclosure to the Club's physician of all present or prior physical or mental defects, illnesses, injuries, or conditions known to him or of which he has knowledge, which might prevent, hinder, or impair the performance of his services under his standard player contract. Player further warrants that at the time of his physical examination by the Club's physician on the \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_, he has not withheld or failed to disclose any present or previous physical or mental defect, illness, injury, or condition known to him. Player understands and agrees that if any answers given during said physical examination are false or if any information has been withheld, such physical examination will be void and will necessitate the taking of another physical examination to determine the true physical status of the player. Player further agrees to indemnify and hold the Club harmless from the consequence of any injury, illness or deteriorated condition occurring to player during the life of his standard player contract which is attributable to or the result of any defect, illness, injury or condition which player failed to disclose to the Club at the time of his examination.

WORKERS COMPENSATION BENEFITS MAY BE DENIED IF MEDICAL HISTORY IS DETERMINED TO BE FALSE.

Date: 4-24-97

  
PLAYER'S SIGNATURE

December 18, 1996

*Mickell*  
DARREN MIKAL:

Darren Mikal is here for his left knee. He had a hyperextension injury to the knee. He complains of pain in the front of the knee.

He is tender over the patellar tendon and has no tenderness over the patella. His range of motion is full.

IMPRESSION: Strain, patellar tendon.

Symptomatic measures were suggested.

November 27, 1996

**DARREN MICKELL:**

Darren is here for his right foot. He developed some pain in his right foot during the game about the first half, and then it got worse. He came in for x-rays, which were negative. He complains of pain over the lateral border of the midfoot-forefoot area.

He is tender when I push underneath the fifth metatarsal head, but the pain is more at the base near the midfoot laterally. There is no tenderness medially and no swelling. His neurovascular status is intact.

**IMPRESSION:**

Sprain to the midfoot-forefoot area laterally.

We will treat this symptomatically with support and treatment and see how he does.

MICKELL-0686

A0802

November 18, 1996

**DARREN MICKELL:**

Darren is here for his right elbow and hand. He states that he had injured this before his suspension and then he re-aggravated it yesterday. He has some pain on the medial side of the elbow, and he states he had a hard time straightening it out after the game.

Exam of his elbow shows that he has some tenderness medially, no instability, pain with stressing the elbow, some pain with full extension and flexion. But he appears to have full motion. He also has some swelling and tenderness over the dorsum of the right hand, but full motion.

We will get some x-rays of these areas.

He also sprained his left ankle, but he has no swelling.

I have suggested symptomatic measures for this.

MICKELL-0687

A0803

# Southern Orthopaedic Specialists

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Gregor J. Hoffman, M.D.

Daniel C. Riordan, M.D.  
Retired  
J. Kenneth Saer, M.D.  
Retired  
OFFICE ADMINISTRATOR  
Marion Eigenbrod

RE: Darren Mickell  
Our file: 11-7498-2  
Our account: 6800

November 25, 1996 TLH Mr. Mickell is here for his right foot. He is complaining of pain in the lateral border of his foot. He is here for x-rays.

X-rays taken in AP, lateral and oblique views reveal no evidence of any fractures.

Terry L. Habig, M. D.

TLH/cc  
cc: Mr. Tom Benson  
cc: Mr. Rick Venturi  
cc: Mr. Dean Kleinschmidt  
cc: Mr. Bill Kuharich

11/25/96

640 Read Boulevard, Suite 120  
New Orleans, Louisiana 70127-3125  
(504) 244-9720  
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MICKELL-0688

A0804

P. 82

FROM : Panasonic FAX SYSTEM

PHONE NO. :

Nov. 18 1995 09:55AM PI

CYBEX ISOKINETIC TEST EVALUATION

cybex hospital

PATIENT: darren . mickell

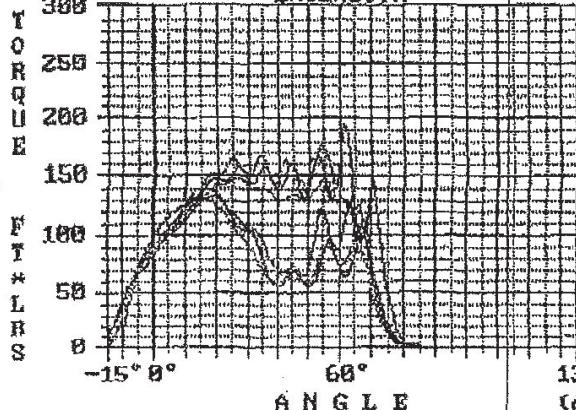
KNEE EXTENSION/FLEXION

BI-LATERAL 1 TRIAL REPORT

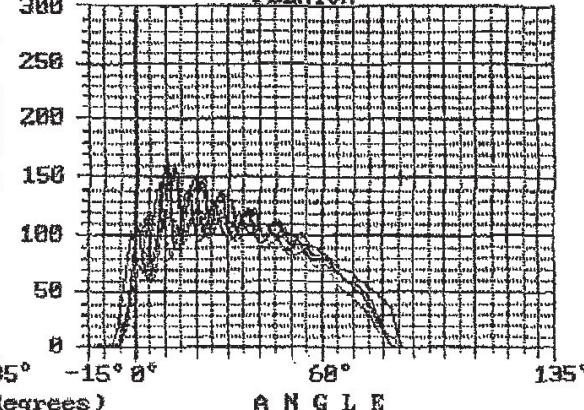
BODYWEIGHT 295 lbs 265 lbs

SPEED 90 DEG/SEC LEGEND: TEST1 RU average points,maximum points,best work  
TEST2 LI average points,maximum points,best work

EXTENSION



FLEXION



SIDE(S) TESTED/DATE(S)	RU	10/09/1996	LI	10/04/1996	DEFICIT %	
SPEED (deg/sec)	90	180	300	90	180	300
FLEXION						
PEAK TORQUE (ft-lbs)	154	132	102	163	118	79
PEAK TORQUE %BW	54%	46%	37%	57%	40%	27%
TOTAL WORK (BWR,ftlbs)	138	95	74	128	79	55
TOTAL WORK (BWR) %BW	48%	33%	25%	44%	37%	19%
Avg. Power (BWR, WATTS)	171	231	898	166	194	217
Avg. Power (BWR) %BW	60%	61%	104%	58%	62%	76%
TOTAL WORK (ftlbs)			606		476	
ENDURANCE RATIO			72%		69%	
EXTENSION						
PEAK TORQUE (ft-lbs)	192	203	170	139	143	131
PEAK TORQUE %BW	67%	71%	59%	48%	50%	45%
TOTAL WORK (BWR,ftlbs)	182	167	153	127	120	117
TOTAL WORK (BWR) %BW	68%	58%	53%	44%	48%	41%
Avg. Power (BWR, WATTS)	244	419	620	162	897	465
Avg. Power (BWR) %BW	65%	147%	217%	56%	104%	163%
TOTAL WORK (ftlbs)			1321		942	
ENDURANCE RATIO			136%		107%	
FLEXION/EXTENSION RATIO AND ROM						
PEAK TORQUE	81%	65%	63%	118%	60%	40%
TOTAL WORK (BWR)	73%	56%	48%	100%	65%	47%
AVERAGE POWER (BWR)	70%	55%	48%	102%	65%	46%
TOTAL WORK			48%		50%	
AVERAGE ROM (DEGREES)	95	104	112	94	104	107
MAX ROM		(118)		(111)		(115)

COMMENTS

SIGNED \_\_\_\_\_  
DATE \_\_\_\_\_

(c) COPYRIGHT LUNEX 1991, 1992

MICKELL-0689

A0805

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Gregor J. Hoffman, M.D.

Daniel C. Riordan, M.D.  
Retired  
J. Kenneth Saer, M.D.  
Retired  
OFFICE ADMINISTRATOR  
Marion Eigenbrod

RE: Darren Mickell  
Our file: 11-7498-2  
Our account: 6800

November 18, 1996 TLH X-ray's of Darren's right elbow  
in multiple views and x-ray's of his  
right hand in AP, lateral and oblique views are negative for  
fractures.

Terry L. Habig, M. D.

TLH/cc  
cc: Mr. Tom Benson  
cc: Mr. Rick Venturi  
cc: Mr. Dean Kleinschmidt  
cc: Mr. Bill Kuharich

*(Terry L. Habig)*

640 Read Boulevard, Suite 120  
New Orleans, Louisiana 70127-3125  
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MICKELL-0690

A0806

Oct-04-96 12:59P

1/4/96  
P.02  
File in  
D. MICKELL

DARREN MICKELL  
DAILY TRAINING SCHEDULE

DAY	TRAINING SITE	TIME
AM SESSION		
MWF	Mackie Shilstone Pro Spa	8:30 a.m.
T-TH	Kenner Regional Medical Center	10:00 a.m.
SAT.	Mackie Shilstone Pro Spa	9:00 a.m.
PM SESSION		
M-F	Kenner Regional Medical Center	1:30 p.m.

NOTE: You will eat lunch daily at 12:00 noon at the Kenner Regional Medical Center Cafeteria with a prescriptive meal. You will be provided with a take-home dinner which will be able to be heated up in a microwave.

You are scheduled for testing at Kenner Regional Medical Center on Monday at 9:00 a.m. for a metabolic study and 10:00 a.m. for a VO2 max test on a stationary cycle. (You need to be fasting.) These tests have been ordered by your team physician, Dr. Charles Brown, to be used to determine the appropriate heart rate training rates for your cardiovascular training. In addition the data will give us insight into the design of your meal plan as well.

Mackie Shilstone Pro Spa  
2111 St. Charles Avenue  
New Orleans, LA 70115  
504-566-1212 EXT. 3051

Kenner Regional Medical Center  
180 West Esplanade Avenue  
Kenner, LA 70065

The Fitness Center 464-8673  
Physical Therapy 464-8173

MS/401  
9806.01

MICKELL-0691

A0807

Julian H. Sims, M.D. • Edward L. Soll, M.D. • Michael R. Voth, M.D. • Coleman S. Schneider, M.D.  
John L. Heard, M.D. • Daniel R. Rovira, M.D. • Richard B. Levine, M.D.

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TERRY HABIG, M.D.  
2731 NAPOLEON AVE.  
NEW ORLEANS, LA 70115

DARREN MICKEL  
5800 AIRLINE HWY.  
METAIRIE, LA 70003

111

TERRY HARRIG M.D.  
2731 NAPOLEON AVE.  
NEW ORLEANS LA 70111

NEW ORLEANS, LA 70115

DARRON MICKEL  
5800 AIRLINE HWY.  
METAIRIE, LA 70003

DATE OF EXAM	DATE TRANSCRIBED	FILM #	REPORT VIA	AGE	DATE OF BIRTH	PHONE #
10/01/96	10/02/96	076519	AUTOFAX	26	70	(504)000-0000

## LIMITED BONE SCAN - FOOT, EEL AND ANKLES

The patient presented for evaluation of the face and neck with pain in the right side of the face and neck for 1 month.

Approximately 20 mCi of Tc-99m HMPAO tracer material were utilized.

distal to the point of entry and anterior to the point of entry. A second, more distal, focal area of increased activity is in the region of the left proximal foot. The two areas are approximately 10 cm apart. The left distal foot area is associated with a slightly brighter region, the leading edge being at the base of the middle toe, and a second, slightly smaller, focal area of increased activity being identified in the distal phalanx region of the middle toe. The left distal foot area is brighter than the right, and the two areas are of approximately equal intensity. The right distal foot area is associated with a slightly brighter region, the leading edge being at the base of the middle toe, and a second, slightly smaller, focal area of increased activity being identified in the distal phalanx region of the middle toe. The right distal foot area is brighter than the left, and the two areas are of approximately equal intensity.

1600 AT THE JEWEL

10. *Leucosia* (Leucosia) *leucostoma* (Fabricius) (Fig. 10)

and for allowing us to practice this

## Radiology

MICKELL-0692

A0808

# Southern Orthopaedic Specialists

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Gregor J. Hoffman, M.D.

Daniel C. Riordan, M.D.  
Retired  
J. Kenneth Saer, M.D.  
Retired  
OFFICE ADMINISTRATOR  
Marion Eigenbrod

RE: Darren Mickell  
Our file: 11-7498-2  
Our account: 68000

September 24, 1996 TLH X-rays of his right elbow are negative for a fracture. X-rays of the right big toe show a small dorsal spur on the proximal phalanx. There is no evidence of a fracture.

Terry L. Habig, M. D.

TLH/cc  
cc: Mr. Tom Benson  
cc: Coach Jim Mora  
cc: Mr. Dean Kleinschmidt  
cc: Mr. Bill Kuharich

TLH

40 Read Boulevard, Suite 120  
New Orleans, Louisiana 70127-3125  
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3800 Houma Boulevard, Suite 210  
Metairie, Louisiana 70006-4151  
(504) 455-9500  
FAX 455-1617

MICKELL-0693

A0809

September 5, 1996

DARREN MICKELL:

Darren is here for his right knee. He states that he got hit in the game on the knee on the front and has developed some swelling. The knee that usually gives him a problem is more his left knee. But he states his right knee bothers him some.

Exam shows just a little thickening of the knee, some pain or tightness with flexion, no instability, negative McMurray's test.

IMPRESSION:

Contusion with slight swelling.

We will treat this symptomatically.

September 23, 1996

DARREN MICKELL:

Darren is here for three things. The first is he got hit on the left anterior hip area early in the game and has some soreness over this hip flexor. He also got hit on the right elbow. He complains of pain on the medial side of the elbow. He has some tenderness and swelling there. Motion is full. The elbow feels stable. But he has pain when I stress the ulnar collateral ligament or medial collateral ligament. He also complains of pain in his right big toe.

Exam shows that he has no swelling. He has pain with motion. He has some restricted motion.

We will get some x-rays of his right elbow and right big toe.

MICKELL-0694

A0810

August 14, 1996

DARREN MICKELL:

Darren Mickell is here for his back.

He has been frantically trying to get in shape for the past couple of days. Running and doing some lifting, he has developed some increased back soreness. The stretching has helped. He has no leg pain, no paresthesias. There is no bowel or bladder incontinence.

Back motion is full. He has a little tightness with extension or pain with extension. He has a little tenderness in the lower lumbar area, no spasm. Reflexes are symmetrical. Straight-leg-raise is negative to 90 degrees, no weakness.

I think that he has strained his back just from overdoing it.

Symptomatic measures are suggested.

August 21, 1996

DARREN MICKELL:

Darren Mickell is here for his left knee. His left knee has had a couple of operations. He has chondromalacia, and it has been sore. It has not been swelling. He has no history of injury.

Exam shows that he has no effusion. He has full motion. He does have some mild-to-moderate patellofemoral crepitus with range of motion.

Just symptomatic measures are recommended, avoidance of squats, ice after activity. He is on anti-inflammatory medicine and tolerating it okay. He is wearing a knee sleeve.

MICKELL-0695

A0811



# NEW ORLEANS LOUISIANA SAINTS

Many drugs are harmful to individuals participating in strenuous physical activity.

It is important that you discuss with your doctor any drugs you are now taking.

Do not take any medication in Training Camp unless prescribed to you by the Team Physician.

I understand the above.

7-11-96  
DATE

Darren Mickell  
SIGNATURE

Darren Mickell  
PRINT NAME



5800 Airline Highway • Metairie, LA 70003 • (504) 733-0255

ADMINISTRATION  
Fax (504) 731-1782

MEDIA RELATIONS  
Fax (504) 731-1888

PLAYER PERSONNEL  
Fax (504) 731-1768

TICKET OFFICE  
Fax (504) 731-1707

MICKELL-0696

A0812

NEW ORLEANS SAINTS FOOTBALL C 3  
PLAYER'S HEALTH HISTORY

NAME: <u>Darren Mickell</u>	HOME PHONE #: <u>816-537-8563</u>	
ADDRESS: <u>Lee's Summit</u>	CITY: <u>KS</u>	STATE: <u>MO</u> ZIP: <u>64082</u>

1. IF YOU HAVE HAD ANY OF THE FOLLOWING, PLEASE CHECK (✓) BESIDE THAT ITEM:

MUMPS	<input type="checkbox"/>	RUPTURE	<input type="checkbox"/>	STOMACH, LIVER OR BOWEL DIS.	<input type="checkbox"/>
SCARLET FEVER	<input type="checkbox"/>	HEMORRHOIDS	<input type="checkbox"/>	BONE OR JOINT DEFORMITY	<input type="checkbox"/>
DIPHTHERIA	<input type="checkbox"/>	TUMOR, GROWTH, CANCER	<input type="checkbox"/>	LOSS OF FINGER, TOE, ETC.	<input type="checkbox"/>
PNEUMONIA	<input type="checkbox"/>	KIDNEY STONE OR INFECT	<input type="checkbox"/>	PAINFUL SHOULDER OR ELBOW.	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	SKIN DISEASE	<input type="checkbox"/>	"TRICK" OR LOCKED KNEE	<input type="checkbox"/>
HAY FEVER	<input type="checkbox"/>	VENEREAL DISEASE	<input type="checkbox"/>	BACK TROUBLE	<input checked="" type="checkbox"/>
ASTHMA	<input type="checkbox"/>	FREQUENT HEADACHES	<input type="checkbox"/>	LEG CRAMPS	<input type="checkbox"/>
GOITER (THYROID)	<input type="checkbox"/>	DIZZY OR FAINTING	<input type="checkbox"/>	FOOT TROUBLE	<input type="checkbox"/>
TUBERCULOSIS	<input type="checkbox"/>	VISUAL DIFFICULTIES	<input type="checkbox"/>	CAR, TRAIN, AIR SICKNESS	<input type="checkbox"/>
FREQUENT SORE THROAT	<input type="checkbox"/>	EAR, NOSE, THROAT DIS.	<input type="checkbox"/>	DIFFICULTY SLEEPING	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	CHRONIC, FREQUENT COLDS	<input type="checkbox"/>	DEPRESSION OR NERVOUSNESS	<input type="checkbox"/>
HEART MURMUR	<input type="checkbox"/>	SINUSITIS	<input type="checkbox"/>	LOSS OF MEMORY	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	CHEST PAIN OR PRESSURE	<input type="checkbox"/>	CHRONIC COUGH	<input type="checkbox"/>
NIGHT SWEATS	<input type="checkbox"/>	APPENDICITIS	<input type="checkbox"/>	FREQUENT INDIGESTION	<input type="checkbox"/>

2. HAVE YOU EVER: (ANSWER YES OR NO)

WORN GLASSES NO LIVED WITH ANYONE WHO HAD TUBERCULOSIS NO  
WORN HEARING AIDS NO BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION NO  
JITTERED OR STAMMERED NO HAD ANY REACTION TO SERUM, DRUGS OR MEDICINE NO  
WORN A BACK BRACE OR SUPPORT NO

3. LIST ALL OPERATIONS, FRACTURES, INJURIES, AND SERIOUS ILLNESSES THAT YOU HAVE HAD:

30 Sept 1996  
2nd Right Kid

---

---

---

---

---

4. ARE YOU TAKING ANY MEDICATIONS AT THIS TIME? \_\_\_\_\_ WHAT? \_\_\_\_\_

5. ARE THERE ANY SERIOUS ILLNESSES IN YOUR IMMEDIATE FAMILY? \_\_\_\_\_ PLEASE LIST ILLNESSES:  
\* NOTE: LIST "L & W" IF LIVING AND WELL - LIST "DEC." IF DECEASED.

MOTHER \_\_\_\_\_

FATHER \_\_\_\_\_

BROTHERS & SISTERS \_\_\_\_\_

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION AND THAT IT IS TRUE THE BEST OF MY KNOWLEDGE.

8/11/96

DATE

PLAYER'S SIGNATURE

MICKELL-0697

A0813



## NEW ORLEANS SAINTS FOOTBALL / JB

## ORTHOPEDIC EXAMINATION

NAME Darren MichellDATE 8/11/961. NECK:History of Injury: No  Yes  (If Yes, Describe)Range of Motion: Normal  Restricted 2. SHOULDER:History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe) <sup>1934 Sep. 1995</sup> out 4 weeks '95  
100% from AC Mr. 1 man footRange of Motion: Right: Normal  Restricted  Left: Normal  Restricted 3. ELBOW SECTION:History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe) 11/94 (1) left epiphysisRange of Motion: Right: Normal  Restricted  Left: Normal  Restricted 4. WRIST:History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe)Range of Motion: Right: Normal  Restricted  Left: Normal  Restricted 5. HAND:History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe)Range of Motion: Right: Normal  Restricted  Left: Normal  Restricted 6. FINGERS:History of Injury: Right: No  Yes  Left: No  Yes  (If Yes, Describe) <sup>1934) Hand 10%</sup> 10% of all fingers

Deformity:

7. SPINE:History of Injury: No  Yes  (If Yes, Describe) 1991, low back tightness

MRI 6/1991: no ruptured disc

Posture: Straight, except tight hamstringRange of Motion: Normal  Restricted

NAME: \_\_\_\_\_

Page 2

8. HIP:

History of Injury: Right: No  Yes \_\_\_\_\_ Left: No  Yes \_\_\_\_\_ (If Yes, Describe) \_\_\_\_\_

Range of Motion: Right: Normal \_\_\_\_\_ Restricted \_\_\_\_\_ Left: Normal \_\_\_\_\_ Restricted \_\_\_\_\_

9. KNEE:

History of Injury: Right: No \_\_\_\_\_ Yes  Left: No \_\_\_\_\_ Yes  (If Yes, Describe) NSA Anti-inflamm.  
more than 0

Measurements: Thigh: Right \_\_\_\_\_ Left \_\_\_\_\_ Calf: Right \_\_\_\_\_ Left \_\_\_\_\_  
Motion and Stability: Right: 2+ flex; 45° exten; stable

Left: 2-3+ flex IP; 45° exten; stable

10. ANKLE:

History of Injury: Right: No \_\_\_\_\_ Yes \_\_\_\_\_ Left: No \_\_\_\_\_ Yes  (If Yes, Describe) out with 95% func 193 + 195

Range of Motion: Right: Normal \_\_\_\_\_ Restricted \_\_\_\_\_ Left: Normal \_\_\_\_\_ Restricted \_\_\_\_\_

Stability: Right: \_\_\_\_\_ Left: \_\_\_\_\_

11. FOOT:

History of Injury: Right: No \_\_\_\_\_ Yes  Left: No \_\_\_\_\_ Yes  (If Yes, Describe) ROM extens

12. ACHILLES:

History of Injury: Right: No  Yes \_\_\_\_\_ Left: No  Yes \_\_\_\_\_ (If Yes, Describe) \_\_\_\_\_

GENERAL REMARKS: Not on condition of being patient

8/11/96

Date

JHH

Physician's Signature

**WARRANTY OF FULL DISCLOSURE OF THE  
PHYSICAL AND MENTAL CONDITION OF PLAYER**

To: New Orleans Saints  
5800 Airline Highway  
Metairie, LA 70003

Player warrants and represents that he has made a full and complete disclosure to the Club's physician of all present or prior physical or mental defects, illnesses, injuries, or conditions known to him or of which he has knowledge, which might prevent, hinder, or impair the performance of his services under his standard player contract. Player further warrants that at the time of his physical examination by the Club's physician on the 11 day of August 1996, he has not withheld or failed to disclose any present or previous physical or mental defect, illness, injury, or condition known to him. Player understands and agrees that if any answers given during said physical examination are false or if any information has been withheld, such physical examination will be void and will necessitate the taking of another physical examination to determine the true physical status of the player. Player further agrees to indemnify and hold the Club harmless from the consequence of any injury, illness or deteriorated condition occurring to player during the life of his standard player contract which is attributable to or the result of any defect, illness, injury or condition which player failed to disclose to the Club at the time of his examination.

WORKERS COMPENSATION BENEFITS MAY BE DENIED IF MEDICAL HISTORY IS DETERMINED TO BE FALSE.

Date: \_\_\_\_\_

John A. Smith  
PLAYER'S SIGNATURE

**Baptist Medical Center**



HEALTH MIDWEST

**SPORTS MEDICINE DISCHARGE REPORT**

Patient Name:	Darren Mickel	Date of Re-Eval:	8/1/96
Patient No.:	80080735	Medical Record #:	355741
Diagnosis:	L4/L5 protruding disc	Onset Date:	Insidious
Physician:	Dr. Habig	Expected visits until D/C:	0

**PROGRESS SUMMARY:**

Mr. Mickel was seen at the Baptist Sports Medicine Department two times from 6/26 through 6/27/96. He did not show for scheduled visits four times from 6/28/96 through 7/3/96.

The client's treatment consisted of trunk/pelvic flexibility and strengthening, with emphasis on hip/lower extremity flexibility and trunk stability, specifically the lower abdominals and gluteal musculature. The client was progressing as expected, performing the exercise program without any signs of discomfort/dysfunction.

We have not seen Mr. Mickel since 6/27/96 and assume he is in no further need of supervised physical therapy at this time.

If there is anything further we can do for Mr. Mickel in the future, please do not hesitate to contact us.

Thank you for this referral.

Professionally,

A handwritten signature in black ink that reads "Michael J. Bolander, P.T.".

Michael J. Bolander, P.T.

MB:bam accutype

cc: Dean Kleinschmidt  
ATC Head Trainer  
New Orleans Saints

**Dan H. Anderson**

President

6601 Rockhill Road ■ Kansas City, MO 64131 ■ 816/276-7000

MICKELL-0702

A0818



# NEW ORLEANS LOUISIANA SAINTS

## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize Kansas City Chiefs  
Name of Team

who treated Darren Mickell to  
Full Name of Patient

release to Terry L. Habig, M.D. and/or Charles L. Brown, Jr., M.D.

5800 Airline Highway Metairie LA 70003

the following information from my medical record.

- Diagnoses, including those relating to alcohol or drug abuse, if any
- History and Physical Examination reports
- Consultation
- Laboratory and X-ray reports
- Physician's Progress Notes
- Physician's Discharge Summary
- Complete Hospital Record
- Operative Report
- Other: \_\_\_\_\_

I understand that the information indicated above is considered confidential and is to be utilized by the recipient only for the following purpose:

- For treatment by the physicians indicated above
- For processing of my insurance claim
- For application of insurance
- Other: \_\_\_\_\_

Specify other limited purpose

I understand that I may revoke this consent at any time, and that in any event, it will expire one (1) year from this date, unless sooner revoked, and that upon fulfillment of the above-stated purpose this consent will automatically expire without my express revocation.

Signed Ken D. Marjim  
Witness

Signed

Terry L. Habig  
Patient

Patient's Date of Birth & SS#

4-28-96

Date of Signature

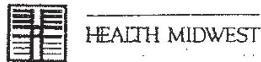


6900 Saints Dr. • Metairie, LA 70003 • (504) 733-0255 • Fax (504) 733-8325

MICKELL-0703

A0819

**Baptist Medical Center**



**PHYSICAL THERAPY EVALUATION SUMMARY**

Patient Name:	Darren Mickell	Date of Eval:	6/26/96
Patient No.:	80080735	Medical Record #:	355741
Diagnosis:	L4-L5 protruding disc	Onset Date:	Insidious
Physician:	Dr. Habig	Case Manager:	

A copy of the detailed evaluation is available upon request. If you have any questions or modifications regarding his treatment, please contact our office at any time.

**ASSESSMENT:**

L4-L5 disc protrusion.

The client demonstrates deficits in the following areas:

1. Decreased postural awareness.
2. Decreased lumbar spine range of motion compared to AMA guidelines.
3. Decreased pelvic/lower extremity flexibility.
4. Decreased trunk/pelvic strength.
5. Specific tenderness along the right lumbar paraspinals and quadratus lumborum musculature.

**GOALS:**

**Short Term:**

1. Demonstrate increased postural awareness.
2. Lumbar spine range of motion to within AMA guidelines.
3. Pelvic/lower extremity flexibility increased by 10%.
4. Lower abdominal/gluteal strength increased by one muscle grade.
5. Independence in a home exercise program.

**Long Term:**

1. Lumbar spine range of motion within normal limits.
2. Pelvic/lower extremity flexibility within normal limits.
3. Trunk/pelvic stability to within normal limits.
4. Return to pre-injury level of activity including professional football.

**Dan H. Anderson**  
President

6601 Rockhill Road ■ Kansas City, MO 64131 ■ 816/276-7000

MICKELL-0704

A0820

MEDICAL  
LABORATORY

NAME: MICKELL DARREN	NS: OMG	1134 04/26/95	PG 1
H# : 12781	ROOM: [REDACTED]	DR: WAECKERLE, JOE	- C51275
R# :	DOB: 1970	SEX: M AGE: 24Y	

ACCT#	RESULTS	ABNORMAL	NORMAL LO HI	UNITS
		RESULTS		
9983 C: 2043 04/25/95				
COMPLETE UA				
/ COLOR	STRAW			
/ TRANSPARENCY	CLEAR			
/ SP. GRAV	1.021			
/ PH	7			
/ PROTEIN	NEGATIVE			
/ GLUCOSE	NEGATIVE			
/ RED SUB	NOT APPLICABLE			
/ KETONE	NEGATIVE			
/ BILE	NEGATIVE			
/ OCC. BLD	NEGATIVE			
/ NITRITE	NEGATIVE			
/ URINE LEUKOCYTE	NEGATIVE			
/ UROB	NORMAL			
/ WBC	NONE SEEN			
/ RBC	NONE SEEN			
/ SG. EPIT	FEW			
/ CAST	NONE SEEN			
/ CAST	NONE SEEN			
/ CRYSTAL	NONE SEEN			
/ CRYSTAL	NONE SEEN			
/ OTHER	NONE SEEN			
/ OTHER	NONE SEEN			
9984 C: 2043 04/25/95				
CHEM 26				
/ GLUCOSE	94		70 110	MG/DL
/ UREA N	13		6 22	MG/DL
/ CREATININE		1.4	.5 1.2	MG/DL
/ BUN/CREATININE	9			
/ URIC ACID	6.6		2.5 9.2	MG/DL
/ CALCIUM	9.9		8.7 10.7	MG/DL
/ PO4	3.6		2.6 4.9	MG/DL
/ ALK PHOS	71		37 107	U/L
/ T. BILI	.6		.2 1.2	MG/DL
/ TOTAL PROTEIN	7.3		6.1 8.2	G/DL
/ ALBUMIN	4.3		3.5 5.0	G/DL
/ GLOBULIN	3.0		1.4 3.5	G/DL
/ AG RATIO	1.4		1.1 1.8	
/ LDH	204		110 188	IU/L
/ GOT	43		10 45	U/L
/ GPT	33		11 44	U/L
/ GGTP		76	8 69	U/L
/ CHOLESTEROL	175		100 199	MG/DL

MICKELL DARREN

SPECIMEN CONTINUED

PG 1

751056

MICKELL-0705

A0821

(A)

MEDICAL  
LABORATORY

NAME: MICKELL DARREN	NS: OMG	1134 04/26/95	PG 2
H# : 12781	ROOM: [REDACTED]	DR: WAECKERLE, JOE	- C51275
R# :	DOB: [REDACTED] 1970	SEX: M AGE: 24Y	

ACC#	RESULTS	ABNORMAL	NORMAL	UNITS	T
		RESULTS	LO HI		
/ TRIGLYCERIDES		204	35 200	MG/DL	
/ HDLC		45	45 100	MG/DL	
/ LDL		89	0 160	MG/DL	
/ VLDL		41		MG/DL	
/ SODIUM		143	135 148	MMOL/L	
/ POTASSIUM		4.3	3.5 5.3	MMOL/L	
/ CHLORIDE		102	100 112	MMOL/L	
/ IRON		88	45 160	UG/DL	
/ RPR	NON REACTIVE				
/ T4		6.5	4.0 11.0	UG/DL	
/ ULTRA SENS. TSH		1.6	4 6.1	MICIU/ML	
CEC					
/ WBC		7.0	3.8 10.1	K/CMM	
/ RBC		5.26	4.40 5.80	M/CMM	
/ HEMOGLOBIN		15.6	13.8 17.2	G/DL	
/ HEMATOCRIT		47.2	41 50	%	
/ MCV		90	81 100	FL	
/ MCH		29.7	27 34	PG	
/ MCHC		33.2	31 37	GM/DL	
/ RDW		13.3	0 14.8	%	
/ PLAT CT		260	150 400	K/CMM	
/ NEUTROPHI		52.6	%		
/ LYMPH		37.7	%		
/ MONO		6.3	%		
/ EOS		2.7	%		
/ BASO		1.7	%		
MICKELL DARREN		END OF REPORT			P
		WAECKERLE, JOE	- C51275		
KANSAS CITY CHIEFS					
1 ARROWHEAD DRIVE		KCMO 64129			

754057

MICKELL-0706

A0822